Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Alfred Burris, M.D. 1328 Southern Ave Suite 214, Washington , DC 20032 32. Begistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0024996

29d. Date signed (Month, Day, Year)

April 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Decedent's Name (First, Middle, Last)

Dohn Bruce 2. Date of Death McNea1 Month 2008 32 . Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Johns Age (In yls. last birthday) alh ot More Date of Birth (Month, Day, Year) 5. Social Security Number Year | If Under 24 Hrs 6 Sex Birthplace (State or Foreign Country) Days Hours **M**2XM 2□ F Oct 1, 1950 Kentucky 047-46-9886 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Eldersburg 1 □Yes X□No 10e. Street and Number 10f. Zip Code 21784 10g. Citizen of What Country? 2616 Red River Rd. 2016 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Soc. Security Admin. IT Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Don Frank McNeal Doris Bierbaum 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2626 Red River Rd. Eldersburg, Grace McNeal (Wife) MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Pleasant Ridge Cem 4/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespratory Weck resulting in death) Due to (as a consequence of): Appendiced cancer Muc Vietastic COL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Important; if item any injury or othe

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

2

Completed

Be

2

Funeral

Director

an "natural", or items 23a or Medical Examiner must be

death with the Maryland

filed within 72 hours after

permit. Pages Department of H

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vital

Division or

Hospital or Attending

within 24 hours after death.

To the Funeral Director: Completely filled in by the fi

certificate be executed

physician and s the burial-tran attending p signed I cate has I After this certific funeral director,

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an/Me	1
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Certification: To

Medical

Exami

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4 ☐ Homicide

29b. Signature and title of certifie

24a. Was an autopsy performed: **⊘**No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

examiner?						26.	Place of Dea	th (C	heck only one)		
1 Yes 2 No	H	ospital: 1 Inpatient 2	ER/Outpatient	3 🗆 1	DOA	Other: 4	I ☐ Nursing H	ome	5 Residence	6 □Other (Special	fy)
. Manner of Death		28a. Date of Injury	28b. Time of			Injury at Work?			Describe how inj		
1 Natural 5 Pending		(Month, Day Year)	Injury								
2 Accident investigati	on			M		1 ☐ Yes	2 □ No				

investigation 2 Accident 3 Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the cause (s) and manner and due to the cause(s) and manner stated. (Check only one)

RES- 000

29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEI MOKURI

MALFE NORTH 600

STREET BALTIMORE

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day April 20, 2008 20:09 Barbara Marion Modine 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🖾 F New York 80 September 13, 1927 553-32-2983 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 401 Hillmoor Drive 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Department of Recreation Aquatic Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Cullen Winfield S. Lienhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 401 Hillmoor Drive, Silver Spring, MD 20901 Susan Modine / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Apr. 23, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium 22. Name and Address of Facility Robert A. Rockville, Inc., 300 West Rockville, Maryland 20850-Pumphrey Funeral Home/ Montgomery Avenue, -2805 21. Signature of Funeral Service Licensee M01473 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final -THEROSCIERUSII disease or condition resulting in death) Due to (or as a consequence of): MPH ARREST Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

sician and burial-trans

attending physician for use as the buria

cate has been signed by the page 2 should be detached

director,

this After th funeral

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician/Medical

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Completed

Be

Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination used by muffind 21 once.

Maryland 21215-0036

altimore,

Sequentially list conditions, if any, leading to initiotate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 □Yes

25. Was case referred to medical examiner' 1 | Yes 2 | ₩0 27. Manner of Death 5 Pending investigation 1 Datural
2 Accident

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 4 🗌 Homicide 29a. Certifier

(Check only one)

3 Suicide

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

APR 2 5 2008

137188

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLO GEERQ JEUR RU BETHESDA MOZOELY // Inm \$2. Registrar's Signature Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manni Month **Physician** 2008 aymon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Blue Point Nursing & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 2, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☑ M 2 ☐ F 217-20-4246 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County at Item 27 is marked other than "natural", or items 23a or 28a-1 st other traumatic event, the Medical Examiner must be notifiled MD 1 Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2625 W. Belvedere Avenue 21215 Funeral <u>USA</u> American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces

1 X Yes 2 If Yes, Give
Year or Dates: Black, White, etc. be filed within 72 hours after on the filed within 1 Never Married 2 Married 2 🗌 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 2 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk h and Mental H Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or any ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 W. Belvedere Avenue Baltimore, MD Blue Point Nursing & Rehab 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 M Other (Specify) in state S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Rart1. Enter the disease, of complications that caused the death. spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final disease or ndition resulting in death) Physician /Medical a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate caus. End of the first Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physiciar Physician/Medical for use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. I signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 2 No 3 Probably 4 ☐ Unknown 1 Yes Completed been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s perform certificate 1 ☐ Yes 2 ☐ No 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After fy filled in by the funers 28c. Injury at Work? Certification: 5 ☐ Pending investigation Iniury Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at

To the Funeral D

completely filled i Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print) UB

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MP 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® () () Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** April 21, 2008 9:25AM Hildegard M. Mijan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery National Lutheran Home 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 M 2 X F Yrs. September 11,1917 90 Director North Dakota 533-24-0150 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or iteme 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Monrovia 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21770 3969 Rye Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natieny injury or other traumatic event, Ing Maditare once. (Give kind of work done during most of working life. DO NOT use retired) Montgomery College (1-4or 5+) Elementary/Secondary (0-12) County Public Schools 8 Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Herman Johan Brueckner Hulda Strassburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1726 Euclid Street, N.W., Washington, D.C. 20009 Sharon M. Lyden/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. April rium inc. 24, 2008 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or &s a consequence of): FAIVURL **Physician** IMMEDIA TE /Medical Examiner Incontrolled Atrial f. brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine congestive heart failure exacerbationattending physicien and for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Urosepsi IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 99 1 Yes 2 40 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 000 1 ☐ Yes rs after death.
el Director: After this certifical or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C completely filled 25a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the datese(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Mile of certifier April 21,2008 00050612 Imale mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 Samuel G. Maller. M.D. 9701 Veirs Drive, Rockville, Maryland 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Goarde Registrar

			For State Registrar	State of Marylan	•	artment of H rtificate of L		, ,	iene _{eg. No.} 200	8 13506
	Physici	an	1. Decedent's Name (First, Middle, La	Martin Monta	оно М	cDuffy	***	2. Date of Deatl	Dav Ye	3. Time of Death 3:20 PM
-	/Medio		4a. Facility Name (If not institution, gir		gue n		Location of Death	April	21, 200	
)	LXaiiii	CI	Carriage Hill Nu				resda		Montg	omery
	Funeral Director		072-12-4516	Sex 7. Age (<i>In yrs.</i> 1 ☑ M 2 ☐ F 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	Year) 9. 1921 N	Birthplace (State or Foreign Country) ew York
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-fsh	Director	Maryland Montgo	mery	Bethe	sda				1 □Yes 2 🗓 No
	3a or 2		10e. Street and Number 4978 Sentinel D	rivo #501		10f. Zip Code	20816		Og. Citizen of Wha United S	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba			14. Race -	American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is flocified. Examination in once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced		TT	1 □Yes 2⊠No			Specify:	White, etc. White
215-(hin 72 h e. an "natu Medice	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work l)	ing	16b. Kind of Busin	ess/Industry
12	led with			5+	Admin	istrative			Law	
lanc	ld be fil fental F ked otl ic ever	To Be	17. Father's Name (First, Middle, Last Benjamin McDuff				18. Mother's Nam May	e (First, Middle, N Thompson	iaiden Surname)	
lary	2 shou and N is mar aumat	_	19a. Informant's Name/Relationship			ng Address (Street a				
e, S	1 and Health em 27 ther tr		Thomas M. McCarti						ille, Ma	ryland 20850
mo	Pages tent of nt; If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			sition (Name of matory or other plac Crematorium		L 24,		a, Maryland
Baltimore, Maryland	Departm Departm Mporta Iny Inju		21. Signature of Funeral Service-Lice	nsee	Ro	Name and Addres	ss of Facility phrey Fune	ral Home/F	Rockville,	Inc.
			23a, Part 1, 6 ter the disease, or con	M0130 mplications that caused the deat						Land 20850-2805 Approximate
	Physician		shoo for heart failure. List only Immediate Cause (Final disease or condition		RY	ARTER	V D/S	EASE		Interval Between Onset and Death
A. Carrier	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	BRILLA	-			
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. TRIAL Due to (or as a conseq		ORILLA	((0)			
γ.	ecuted and transit	Examiner	Cause. (Disease or injury that initiated events resulting in death) Last	c						
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical E	resulting in obality East	Due to (or as a conseq	uence ot):					
, e	ertifical ling phy e as th	Medi	IF FEMALE:							
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	I death 3	☐ Ectopic pregnancy ☐ Other (specify)	у		23d. Date of Month	
ر. ح.	e law requires that the de has been signed by the e 2 should be detached	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ite to the cause of death?
ord	require een siç rould b	ted k				=		1 ☐ Ye	s 25 No 3[Probably 4 🗍 Unknown
Rec	ne law has b ge 2 sh	Completed						24a. Was ar autops perforn	y prio	re autopsy findings available r to completion of cause of th?
ta	hysician; The la his certificate ha I director, page 2	Be Co	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2	2/20 No 1 □	Yes 2 Dolo
Ž	hysici his ce I direc		examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Othe			nce 6 Other	(Specify)
ouc	ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Work	yat (? Yes 2 ∐No	28d. Describe ho	w injury occurred	
Division of Vital Records,	l or Attending Ph y after death, Director: After thi I in by the funeral c	Certification: To	2 Accident investigatio 3 Suiclde 6 Could not be 4 Homicide determined	De 290 Place of Injury At he	ome, farm, str		165 2 1110	28f. Location (St. City or Town	reet and Number	or Rural Route Number,
ō	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in					h	4-4			
	e Hos 124 ho e Fune letely 1	Medical		hysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To th To th comp	M	29b. Signature and title of certifier			29c. License			9d. Date signed (/	
				Ben, und	- 02g\ /T =		1712	4	4/22	108
-	let1		30. Name and address of person who Troung Bao, M.D.		, ,		#201, Roo	ckville,	Marylan	1 20850
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		1.				
DHI	MH 17 Rev 1/2		APR 2 5 20	08 Seren S	Sport	the second				
					ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Day 8:32 AM M **Physician** April 20, 2008 Fumiko S. Nishi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Neme (If not institution, give street and number) Examiner Prince Georges Laurel Shanti House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex Year) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F 87 04/24/1920 WA Director 538-12-8560 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County show 10a, State 1 ☐ Yes 2 No Item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified Director Potomac MD Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20854-11420 Beechgrove Lane death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3altimore, Maryland 21215-0036 Asian ò 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other. 17. Father's Name (First, Middle, Last) Be Okubi Moto Shitamae Niroku 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 11420 Beechgrove Lane Potomac, MD 20854-Alan A. Nishi/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 22 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2008 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liperise 22. Name end Address of Facility
Rapp Funeral & Cremation Services m00382 Silver Spring, Maryland 20910-Styley Johnnann 933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concestive
Due to (or an consequence of): 4ears Physician /Medical Stenosi Examiner Lears Vitral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physiciar IF FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day for 4□Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be del Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes should 24a, Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 s certificate has lirector, page 2 2 No 1⊟ Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Certification: To Be 1-3315ted examiner? Other: 4 Nursing Home 5 Residence 2 No Hospital 6 NOther (Specify) Llung 1 ☐ Y9¢ 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 27. Many er of Death Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director.

(Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 shaper 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deene J Shapiro M.D. 10810 Conv. 10810 Connecticut Ave. Kensington cena Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

7

Medical

2008 APR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 2008 Anna R. Newlin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔯 Director 039-09-5420 Mar 12, 1924 84 Rhode Island Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nursing aide healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tobias Petrucci Louisa Piacitellie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Newlin/son 18262 Amberson Road Spring Run, PA 17262 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Ucensee Ronald 8. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final **Physician** 2 hranic disease or condition resulting in death) SO /Medical Due to (or as a consequence of) Examiner 00 ardio mu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence off: Examiner DISCASA or Attending Physician: The law requires that the death certificate be executed Chrinie Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached it 1 Yes 2 N 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation M 1 Yes 2 No after death. 2 Accident in by the 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ္ 2060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0004 my R SHED 10 32 Registrar's Signature Month, Day, Year) APR 2 5 31. Date filed (Month, State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 3:15 AM **Physician** 4 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign hrist If Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 ☑ M 2 ☐ F Yrs. 9 216-01-770 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Expriment for motified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Director Itamore altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2123 12. Was Decedent Ever in U.S. Armed Forces? Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 PYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🗗 No Baltimore, Maryland 21215-0036 Specify. Completed by 3♥Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cretar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 50 ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21087 7912 Omega Court MD ennis O'Maileu 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulancy Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-25-2008 Timonium, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
-vans Funeral Chapel + Cremation 21. Signature of Funeral Service Licensee Evans Funeral Chape 8800 Harford Road Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEARS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Be Completed ORUNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After t 5 Pending investigation 1 Natural 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMORE, MD 21204 DOBERMAN MO

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/IDe f perfit C8/9,5/2/08 US
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM/IDb, per EH C879,5/5/08 US
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4-13-2008 23:14^{-M} Joseph A. Pedone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto, Bayview Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 1-29-1918 Birthplace (State or Foreign Country)
 Md • Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 90_{Yrs} Hours 1 X M 2 □ F Director 217-16-4289 Usual Residence of Decedent 10b. Counfy 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examinar must be notified at 1∏Yes 2∏No Director Md. Balto. 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with then of Health and itental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or items. USA -S. Linwood Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12yrs U.S. Government <u>Electronic Technician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pedone Mary Cascio ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailine Address (Street and Number or Rural Route Number, City or Town Sing Zip Code)
617 S. Linwood Ave. Balto. Md. 21214 617 S. Linwood Ave. Wife Florence M. Pedone 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-17-2008 Highview Maus. Fallston 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral HOme 9705 Belair Rd. ce 23a. P. 11. Enter the disease, or complication, that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tementi /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed chronic Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 🖼 Vo 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 16, 2008 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Beleams MD 21017 Elisabeth 13 21 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Box 68760,74 P.O. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	Maryland	-	artment of h		and Me		ene g. No.	08	3511
			Decedent's Name (First, Middle	e, Last)					2	. Date of Death	1	.,	3. Time of Death
	Physicia		James R. Plai	n e						Month April 6	Day 2008	Year	6:00 AM M
,	/Medic Examin		4a. Facility Name (If not institution		r)		4b. City, Town,	or Location of			4c. County	of Death	
	LAGIIIII	CI	325 Lorraine	Avenue			Baltin	nore			Balt	imore	e
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. las	st birthday)	If Under 1 Year Months Days		24 Hrs. 8 Min.	Date of Birth	Year)	9. Birth	place (State or Foreign
	Director		2 215-32-5366	1 ∑ M 2□F	71	Yrs.	Months Days	Hours	1	Date of Birth (Month, Day, Mar 23,	1937	Mary	land
	p. ,		Usual Residence of Decedent		10- City	Taura and a							10d. Inside City Limits
	arylar show	_	10a. State 10b. County		TOC. City,	Town or Lo	cation						1 □ Yes 2 □ No
	Ba-f	cto		imore		Balt:							21
	or 2	Director	10e. Street and Number				10f. Zip Code	1221		10	og. Citizen of '	wnat Cou SA	intry?
	ath v	E	325 Lorraine	_					-:-0/0	fu Van as Na			can Indian,
	er de	Funeral		nk 12. Was Deceder	s?	. 13.	Was Decedent of If Yes, specify Cub	an, Mexican	gin? (Speci i, Puerto Ri	can, etc.)		ck, White	
36	s aft	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced		s: 1 54–63	3	1 ☐ Yes 2X No	Specify:			Specif	y whit	te
8	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or fleme 23a or 28a-f ehow out, the Medical Examiner must be notified at	edit		I's Education	- 31 03		deni's Usual Occu	pation		unk	16b. Kind of B	usiness/Ir	ndustry
Ċ	in 72 "na fedic	Completed	(Specify only highe	st grade completed)	5.)	(Give	kind of work done DO NOT use retire	during most	t of working	7			•
2	with iene.	E	Elementary/Secondary (0-12)	College (1-4c							mair	itena	nce
Maryland 21215-0036	Hyg other	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Middle, M	Maiden Surnai	пө)	
a	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. ie marked other then "natural", or items 23a or 28a-f ehow eumatic event, the Madical Examiner must be notified at	To B	George Hamilton	n Plaine				Mar	rie Bu	ırke			
ar ₂	should and Men marke umatic		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Stree				City or Town	State, Zi	ip Code)
Σ	and 2 Balth a n 27 is		Kathleen Scharf	/step daugh	nter	327	Lorrain	e Aver	nue Ba	altimor	e, MD	2122	.1
อ์	es 1 a of Hex fitem r othe		20a. Method of Disposition		cer	ice of Dispo	osition (Name of matory or other pla	ice)	Da	te 2	20c. Location	- City or T	own, State
Ĕ	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (5		te	,							
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Itam 27 ie marked eny injury or other treumatic engine.		21. Signature of Finanal Service Ronald	itiensee de 10	Faston	2	R. Name and Addr State Ana	ess of Facility	Board	655 W	Ro1+1	mara	Street
m	9 5 5 8		Juni	1 - 1	All'		Baltimore	-			Daiti	more	Street
			23a. Part 1. Enter the disease, o shock, othean failure. List	complications that caus	ed the death.	Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final	U. a	0001	1 -	11						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to dor	as a conseque	ence of):	HOLCH	en					
	Examiner			b									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	eriou of):						- 1			
	cuted	Examiner	that initiated events	c									
o	e exe ien ai irial-t	E	resulting in death) Last	Due to (or	as a conseque	ence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d									
9	ntifica ng pl	Med	IF FEMALE:	1-12//						10.70			
Box	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, oulcor 1⊟Live birth	ne of pregnan 2 ☐ Fetal o		☐Ectopic pregnand	Э				ate of deliver	very Day Year
	e dea	SICI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknowr	at time of dea 1	ath 5[Other (specify)	-					
P.0.	requires that the death certific been signed by the attending p should be detached for use as	Physician/Me		nee contribution to don't		liaa in tha .	adashina sawas a	was in Dark I		23e Did tob	acco use con	dóbute to	the cause of death?
Ś	signe bed	ğ	Part II. Other significant conditi	offs contributing to death		_				1 □ Ye			bably 4 Unknown
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ec	law las b 8 2 sl	Completed	<u>Cbass</u>	ty						24a. Was a autops perform	n 24b.	Were aut prior to c death?	topsy findings available ompletion of cause of
	the cate h	ပ်		<u> </u>							ZINo		2 No
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7	hysi this c	ပ္	1 ☐ Yes 2 € No	Hospital: 1 □ Inpa		R/Outpatie	nt 3131DDA			e 5 Seeside			eify)
Ĕ	Ing P	on:	27. Manner of Death 1 Anatural 5 □ Pendi	ng .	njury Day Year)	28b. Time o Injury	W	uryat ork? ∏Yes 2.27		3d. Describe ho	w injury occu	rrea	
Sic	Attending Physician: ir deeth. ector: After this certifica by the funeral director, p	cat	2 Accident invest 3 Suicide 6 Could	not be	Initiation and have	MA				of Location /St	root and Num	bor or Pu	ral Route Number,
Division of Vital Records,	or Al after of Direction by	ertification:	4 Homicide determ	pined 289. Place of	etc. (Specify)	ne, iarm, st	reet, factory, office	•	20	City or Town	, State)	ou or nu	rai nobie Ngiliber,
_	pital ours erail	O	29a. Certifier 15 Certifyi	ng Physician: To the be	act of my know	dodgo dog	th convered at the	time date an	ad place, as	ad due to the c	ause(s) and m	anner as	stated
	To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical	Examiner: On the basis	s of examination	on and/or in	vestigation, in my	opinion, dea	ath occurred	d at the time, d	ate and place	, and due	to the cause(s)
	ithin o the omple	Me	29b. Signature and title of certific				29c. Licer	nse number		2	9d. Date sign	ed (Month	n, Day, Year)
	ĕ = ĕ = ĕ		N me	1	10		no.	7601			Clie		
			30. Name and address of persor	who completed cause	of death (Item	2331 (Tuno	Print)	1-711			1/18/4	12	
			LARE SIL VII	ALLIA LIM	a	11 5-	Stem Bi	ad B	o I Lim	2 40	71771		
	Sta	ate	31. Date filed (Month, Day, Year	32/Reg	istrar's Signati	ure	STEEL IN	C S	UITIVE	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(144)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARTIL Payzi, 06:30PM EYZR218 **Physician** Patricia A. Principio /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)

Center **Examiner** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 16), 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛣 F 56 213-52-9340 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside Cify Limits 10a. State 10b. County show or 28a-f show notified at 1√TYes 2 □ No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be n once. 6209 Chinquapin Parkway 21239 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be dolores Mosmiller John Paul Mannion ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6209 Chinquapin Parkway Baltimore, MD 21239 Justin Principio/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Runeral Service Lice State Anatomy Board 655 W. Baltimore Street Wade Director Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. 21201 23a. Part1. shock, Immediate Calise (Final disease or condition resulting in death) SEPTIC SHOCK Physician /Medical Due to (or as a consequence of): PERFORATED BOWEL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or es a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed PANCREATIC CANCER physician and s the burial-tran: Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown RENAL INSUFFIENCY page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RESPIRATORY FAILURE autopsy performed' 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified W D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 LINTHICUM. M. D. RICHARD L. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Carol Pu //en imore, Maryland 21215-0036

7))
Division or Vital Records, P.O. Box 68760, 7		Baltimore
To the Hospital or Attending Physician: The law requires that the death certificate be executed		permit. Pages 1
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	/sid led am	Important: If ite
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia ic	any injury or ot
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		Plea	se Type or Prin							ble.	
	-	For State Registrar	State of Ma	aryland	•	artment of H rtificate of L		-	giene Reg. No. 20	08	13513
Physicia		Decedent's Name (First, Middle	le, Last)					2. Date of De Month	Day	Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution		LL	2/	4b. City, Town, or	Location of Deat	APRI	4c. County		
Examin	<u> </u>	Baltimore Wash	ington Medic			Glen If Under 1 Year	Burnie	T 0 P 1 - (P)			undel
Funeral Director		5. Social Security Number 212-36-9620	6. Sex 7. Ag	e (In yrs. I 67	ast birthday) Yrs.	Months Days	Hours Min.	Sept.	th (Year) 9. Birthplace (State or Foreign Country) MD		
D		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Lo	cation					10d. Inside City Limits
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vith the	Funeral Director	10e. Street and Number	Dond			10f. Zip Code	21060		10g. Citizen of \	What Co USA	ountry?
death v	neral	119 Highland	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H		Specify Yes or No			erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: I fire Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	I If Yes, Give'			1⊡Yes 2火∏No	Specify:	TO RIGATI, etc./	Specif	y: V	hite
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be file ntal Hy ed othe event	Be	17. Father's Name (<i>First, Middle,</i> Carl Lon					18. Mother's Na Edith	ime <i>(First, Middle</i>	, Maiden Surnar TOWS 1		
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permit. F Departm Importar any injui		21. Signature of Funeral Service	- / -	1	2	2. Name and Addre					Home, P.A.
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at the dea by the at tached fo	ysici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of o	death 5	Other (specify) _					
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lor Atten after deatl Director:	27. Natural 2 Accident 3 Suicide 4 Homicide Suicide 4 Homi										
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certify Certify Check only 2 Medica	ying Physician: To the bes al Examiner: On the basis and manners	of examina	owledge, dea ation and/or i	th occurred at the t investigation, in my	ime, date and pla opinion, death o	ace, and due to the	e cause(s) and r e, date and place	nanner a	as stated. ue to the cause(s)
To th within T o th соппр	Me	29b. Signature and the of cortif	1)	R	DM.	29c. Licens 7	12/10	7	1000	1 2	nth, Day, Year) -4 2 005
5		30. Name and address of perso	on who completed cause of	death (Ite	m 23a) (Type	Print)	VG ton	Aus	BACI	-1x	10 89 MD
Sta Regist	ate rar	31. Date filed (Month, Day, Yea APR 25 2	32. Regis	trar's Stan	ature	Print)		71.0	por V =		V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . ^{Day} 2008 April 20, **Physician** 2:10A Charles James Pettiford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, April 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Months Days Hours Min 25,1924 North Carolina 1 ★M 2 ☐ F 237 22 7819 83 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County Maryland Prince George's 1 ☐ Yes 2 No Clinton Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 4925 Plata Street 20735 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WW I I If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: African American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager of Production Printing Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert H. Pettiford Mary E. Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Naomi S. Pettiford (wife) 4925 Plata Street, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 22, 2008 Lee Crematory Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Furieral Sa Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final leukemia (ell 1647 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 formia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Follows Renal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe (61/48C Mutiorgan 1□ Yes 2√TXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Examiner the death certificate be executed and Box 68760, attending physician for use as the buria as the l use P.0. ate has been signed by the page 2 should be detached Division or Vital Records, certificate Attending Physician: after death.

Director: After this certification by the funeral director, 5

Funeral

Director

Show or 28a-f show notified at

"natural", or Items 23a or idical Examiner must be

the Medical

3altimore, Maryland 21215-0036

721

ifled within Hygiene, other than "

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, the

Physician

/Medical

Certification:

within 24 hours aft

To the Funeral Di

completely filled in the State

Hospital

29b. Signature and title of certifier 30. Name and address of person who

28f. Location (Street and Number or Rural Route Number, City or Town, State)

121/08

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

M.O

MD 7501 SURRATTS ROAD, CLINTON, MD 20735 SUITE 307 BHAVIN PATEL.

31. Date filed (Month, Day, Year)

29a, Certifier

Medical



Registrar

D0064801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me 1- State Registrar State of Maryland / Department of Health and Me Certificate of Death	ntal Hygier Reg.	0000 10015
	Physicia	20	1 Decedent's Name (First Middle, Last) 2	. Date of Death	Day Year 3. Time of Deathy
\$1.	/Medic	al -	Parvatiben Bhulabhai Patel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Month 22	2008 9:16 M 4c. County of Death
7	Examin	er	Prince George's Hospital Cheverly		Prince George's
	Funeral		Months Days Hours Min.	 Date of Birth (Month, Day, Ye 	9. Birthplace (State or Foreign Country)
	Director		229-93-2922 1	Dec 18,	
	anylane show d at	-	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 📉 No
	the M 28a-f notifie	Directo	Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: I flee Z1 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the M. dr.al Examiner must be notified at once.		1511 Southern Spring Lane 20774		India
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft al', or Examí	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🖾 No Specify:		Specify: Asian-Indian
21215-0036	"natur dical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		b. Kind of Business/Industry
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ng	tal Hyg d other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		
Maryland	hould I d Men narke	٦	Parsottambhai Patel Harkh: 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural F		Patel
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altimore,	ges 1 a t of He If item or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or Town, State
<u>=</u>	ift. Pag artmen artant: injury		4□Donation 5□Other (Specify) West Arundel Crematory 4/24		denton, Maryland
Ba	permi Depar Impor any ir once.	[-]	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral H 1411 Annapolis Road	ome & Cr Odenton	ematory, P.A. , Maryland 21113
r	5,744		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line.		interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Athors dentic Cardiovascular	Heart	Disease.
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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eco	ne law require has been si ge 2 should b	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Vital	or Attending Physician: The are death. Director: After this certificate he by the funeral director, page	o Be	25. Was case referred to medical examinor? 1 Pres 2 No Conter: 4 Norsing Home		e 6 ⊡Other (Specify)
0 0	ng Ph ífter thi	on: T	27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28 Work?	3d. Describe how	
Division or	oteath.	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be age Place of injury. At home form street factory office.	Bf. Location (Stree	et and Number or Rural Route Number,
2	saler saler al Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, S	itate)
	To the Hospital or Attending Physician: The law requires that the death certiviting 24 hours are refeath. To the Funeral Director: After this certificate has been signed by the attending completely filled by the funeral director, page 2 should be detached for use a	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.		
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
)	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, 3001 Hospital Drive, Cho	I A	pul 23, 2008
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sy vester 300/ 1505p; Tal Drivey Cho	val	Maryland
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	01	
	Registi	ar	APR 2 5 2008 Agree As Agreement		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State ed Maryland / Department of Health and Mental Hygiene

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Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOME Birthplace (State or Foreign Country) If Und Security Number **Funeral** Days 1□M 2√F Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 es 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Black Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a, Informant's Name/Relationship item 27 Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Burial 2 □ Cremation 3 | Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 4905 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cal rdiac or respiratory Immediate Cause (Final CNE MONTH Physician HIDUIZO resulting in death) /Medical two years Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant hed by the attent 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Failure to Thrive 1 ☐ Yes 2/2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 1☐ Yes 2X No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature 4 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Reg 30 PM HPR: 2000 4c. County of Death , or Location of Death N/A IMORR Year If Under 24 Hrs. 8. If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Hours 1□M 2□F 7238 79 20 216 AUG. 24, 1928 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1113 ANDOVER 21218 USA RD. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSING EXTENDER-LPN NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT ROLES RHODA SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1113 ANDOVER RD. BALTO, MD. 21218 PAULETTE DORSEY (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MAY 1,2008 BALTIMORE,MD. 4 □ Donation 5 □ Other (Specify) MT.ZION CEM. 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME ature of Funeral Service Licenses E PRESTON ST. BALTO MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Henst Immediate Cause (Final DUDESTIVE

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

"natural",

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M. once.

Director

Funeral

þ

Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed After

Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director: completely filled in by the f To the Hospital

resulting in death)	a. Due to (v as a consec		7 30.						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):								
IF FEMALE:	d								
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 WNo 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of a 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month D	ay Year			
Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the				
				24a. Was an autopsy performed 1 Yes 2	prior to comp death?	sy findings available bletion of cause of			
25. Was case referred to medical			26. Place of De	ath (Check only one)					
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)				
27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	t and Number or Rural I tate)	Route Number,			
	ysician: To the best of my kn niner: On the basis of examin and manner stated.								
29b. Signature and title of pertifier	7		29c. License number	29d.	Date signed (Month, Da	_			
12660	- P	1.0	D63382	As	12il, 22.	2008			

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 1 Loch Sufficiently (incl), Baltimore,

32 Registrar's Signature

MD 212

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAT

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (Pirst, Middle, Last) 2. Date of Death Year Physician 0420 M 995 /Medical or Location of Death County of Death Examiner Baltimore Lstowr 9. Birthplace Country 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, (State or Foreign **Funeral** sex 1XIM 2□ F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at 10a. State 10b. County City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director HMOre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? edmon Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∐**X**No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cd lege (1-4or 5+) yea(18. Mother's Name (First, Middle, Maiden Surname, . Father's Name (First, Middle Be Informant's Name/Relation 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iedmont Baltimore, MD 20a. Method of Dispositi 20b. Place of Disposition cemetery, crematory 20c. Location - City or Town. 1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livensee Pike 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hearthailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE CONGESTIVE MEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinite under cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy After this certificate 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ADril 23, 2008

Registrar

State

REISTENSTOWN MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

Year)

APR 2

5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SUSAN GAYE ROYAL M A JEG 23 APRIL 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE STELLA MARRIS TIMONIUM Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Country) MARYLAND Months Days 1 □ M 2 🗹 F Hours 213-807172 Director JULY, 11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 Is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examir er must be redified 1 Yes 2 No Funeral Director MD HOWARN JESSUP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA WASHINGTON BLUD 20794 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: Specify: WHITE <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAID HOTEL 11 Pages 1 and 2 should be filed w ment of Heatth and Mental Hygic ant: If item 27 Is marked other I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YVONSA BRUNER ည WILLIAM SEAL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #43 JESSUP, MD 20794 JASON ROYAL HUSBAN RLUA altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DUALLYSON, STANDONAH BOOK, OF 1990 YATELAND YATELAND 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee mattomy gifts registry 7522 collished Dir Handukr madious Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** UTERINE CANCER resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 2X No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this မှ HOSPICE of completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

SUSAN ROYAL

2008

Hospital 24 hours a within 2

> State Registrar

31. Date filed (Month, Day, Year) 2008 APR 25

29b. Signature and title of certifie

TARIQ MAHMOOD

29a. Certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

TIMONIUM, MD 21093

2. Registrar's Sigurture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 310b Per FH G878 4 Parytane of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) RUSSF 2008 2:40pm 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SOR 11 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 4, 1958 7. Age (In yrs. last birthday)
49 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Min. 219-70-3287 1 □ M 2 F MD Usual Residence of Decedent Anne Arundel
Brooklyn 10d. Inside City Limits 10c. City, Town or Location 1 TyYes 2 □ No Brooklyn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3606 Saint Margaret Street 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2X Married White 1 ☐ Yes 2 XXNo Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Carl Lloyd Lilian Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glenn Eugene Russell / Husband 3606 Saint Margaret Street, Brooklyn, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 4/25/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funderal Service Licensee Victor P. Doda Charles L. Stevens Funeral Home Inc. del·19 017 1501 East Fort Avenue, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

permit. Pages 1 and 2 should be filled. Department of Health and Mental Hygin Important: If them 27 is marked any injury or other 1. **Physician** /Medical Examiner certificate be executed attending physician and for use as the hinds to the

signed by the a

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certificate

page 2 s has

funeral director,

To the Funeral Director: After completely filled in by the funera

within 24 hours after To the Funeral Dire

Hospital

death.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

a or 28a-f show t be notified at

7 Is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t

Director

Funeral

à

Completed

Be

should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

68760.

P.O. Box

or Vital Records,

Division or Attending Examine Physician/Medical

þ

Completed

Be

P

Certification:

Medical

IF FEMALE: 23h. Was decedent pregnant in the past 12 months? 9 Unknown

24a. Was an autopsy perform 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Yes 2 No

5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Matural

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier oce

ユル MD 29c. License number

RESOUT

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OMITRI GAGARI SOUTH HANOVER STREET BALTIMORE

State Registrar 31. Date filed (Month, Day, Year) APR 2 5 2008



Box 68760, P.0. Division of Vital Records, this certificate death.

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle, Last) Day Year Month **Physician** Elizabeth Rose 2:00p. Marie 04 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 709 Roundview Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F Months 217-20-7961 90 Director 02 24 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore X□Yes 2□No NA MD Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21225 709 Roundview Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2√☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2√ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: Black 3X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th grade College (1-4or 5+) Angel Haven Nursing Asst. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Williams John Diggs ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 709 Roundview Road, Baltimore, Md Maxtene Brown-Daughter 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 4/29/08 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myccardial Inforction 21215 Approximate Interval Between Onset and Death Physician /Medical Due to (as a consequence of): Examiner Dronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanows St Khandelwal MM 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 04 21 2008 12:10a Sister Thais Riscavage /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 4100 Maple Avenue If Under 1 Year It Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Sociat Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 21 F 12/26/1910 97 Pennsylvania 199 40 8762 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County or 28a-f show the Medical Examiner must be positive at 1 Yes 2 No **Baltimore** Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4100 Maple Avenue 21227 items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Cotlege (1-4or 5+) Religious Sister Nursing in Convent permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If Item 27 is marked other the any injury or other traumatic event, the angles. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sophie Julia Gortz Matthew Riscavage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21227 4100 Maple Avenue Sister Mary Becker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/23/2008 New Cathedral Cem. Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Lice 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence ot): Physician /Medical **Examiner** 10V011a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence ot) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence ot): Box 68760, physician Physician/Medical for use as the tF FEMALE: 23c. It yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.0. the page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 2 12 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case eferred to medical 26. Place of Death (Check only one) examine Hospitat: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 3 DOA Medical Certification: To 1 Inpatient 2 ER/Outpatient 28b. Time of Injury 28d. Describe how injury occurred 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 OVIA 32/Registrar's Signature 31. Date fited (Month, Day, Year) State parks) Registrar APR 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** J 2008 04 Russell Hill Ruffin, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Medical Examiner BURME DALtimore MAShin Center If Under 24 Hrs. 7. Age (In yrs. last birthday, If Under 1 Year Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Min. Director 239-02-5462 52 09-07-1955 North Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21144 United States "natural", or items 23a 1731 Green Meadow Court by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Institute of Health Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Hill Russell Hill Ruffin, Sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1731 Green Meadow Court Severn, Maryland 21144 Carla D. Ruffin / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐Removal from State 04-25-2008 4 □ Donation 5 □ Other (Specify) MD Veterans Ceme. Crownsville, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 M01522 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCAR WAL Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tra Due to (or as a consequence of) P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical the as attending to for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by ✓ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To nours after death. neral Director: After this y filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 17 Rev 1/2001

State Registrar

(Check only one)

29b. Signature and title of certifie

30. Name and addr of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D18426

MARY LAND, 21221

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar			Certificat	e of L	Death		R	eg. No.	JUO	100	60
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			8 PEBBLE DR.				BROOM		*			ARUNDE		
H	Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last birth	Months	1 Year Days	If Under Hours	24 Hrs. Min.	Date of Birth (Month, Day	Year)	Cou		Foreign
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	the N 28a-1	Director	MD ANNE ARU 10e. Street and Number	JNUEL		BROOKLYN 10f. Zij	Code				10g. Citizen	of What Cou	ntry?	
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	eath	Funeral	8 PEBBLE DR. 11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Dece	dent of H	ispanic Ori	igin? (Spe	cify Yes or No-	14. F	lace - Ameri		
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altimore,	t. Pa rtmer rtant: rjury		4 □ Donation 5 □ Other (Spe		BAYVIE	V CREMATO			APR.22	.,2008	BALTIMO	DRE, MD		
g	permit. Pages Department of I Important: If Ite any injury or o once.		21. Signature of Funeral Service	1114		22. Name a	UNERAI	L HOME	, P.A.					
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P.0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician	9 🗆 Unknown											1
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<u>></u>	or At ifter of Direction by	Certification: T	4 Homicide determin	od Zoe. Flace of Inj	ury - At home, fa c. (Specify)	m, street, lacto	ry, office			City or To	vn, State)	amber or ma	nai rioute ivun	iber,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examination an	d/or investigation	on, in my	opinion, de	eath occur	red at the time,	date and pla	ce, and due	to the cause(s	ş)
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	4		Dorothy Sece	y Mig 2	835	Smit	NA	enu	e s	wite	203	Dalte	mere 1	11)
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Ш	Funeral Director			M 2□F	76 Yrs	Months Days		(Month, Da	y, Year)	Coun	ington, D.C.
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	with the	Funeral Director	10e. Street and Number	d		10f. Zip Code	,				•
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ODGE.	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	Korean	1 ☐ Yes 2X No	Specify:		Spec	eify: Whi	te
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Baltimore,	rmit. spartn porta y Inju		21. Signature of Funeral S-rice License)			ress of Facility Rob e, Inc. 30 e, Marylar	ert A. P	umphrey	Funera	l Home/
<u> </u>	S a le s		X.5.	MO(0896	Rockville	e, Marylai	nd 20850) Tronego	mery F	
г			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused cause on each lin	the death. Do not ne.	enter the mode of dy	ring, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)			NEUMONIC	\				days
	/Medical Examiner	Н	resulting in deathy		a consequence of)						
		ia l	Sequentially list conditions, if any, leading to immediate		a consequence of)					_	weels
37	uted 1 ansit	Examiner	Cause (Disease or injury that initiated events		ALNUTR	TIM					menth
o O	be executed ician and burial-transit	Exa	resulting in death) Last		a consequence of)						
760,	icate be executed physician and s the burial-transit	cal	d		a nope	DENOCAR	CINOMA				years
89	that the death certificate ed by the attending physi detached for use as the	Med	IF FEMALE:								
Box	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregnan	су			Date of deliv Month	ery Day Year
0	The law requires that the death certifica ite has been signed by the attending phoage 2 should be detached for use as if	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	time of death	5 ☐ Other (specify)					,
<u>α</u>	that the	F.	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	ne underlying cause g	given in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
Records,	w requires that been signed to should be deta	d by						1 🗆	Yes 2⊠No	3 ☐ Pro	bably 4 □Unknown
COL	w req	Completed						24a. Was	an 24	b. Were auto	opsy findings available
Re	The lav	щ						auto		prior to co death?	ompletion of cause of
tal		Be Co	25. Was case referred to medical				26. Place of Dea			1 ∐Yes	2200
or Vital	lys dir	To B	examiner? 1 Yes 2 No	ospital:	ent 2 ER/Outp	atient 3 DOA	ther: 4 \sum Nursing H	lome 5 ☐ Res	idence 6 🗆 0	Other (Speci	fy)
0	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju			jury at ork?	28d. Describe	how injury occ	curred	
Sio	Attending r death. ector: After by the fune	atic	2 Accident investigation				□Yes 2□No				
Division	or Attendafter death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj building, et	ury - At home, farm c. <i>(Specify)</i>	n, street, factory, office	е		(Street and Nu own, State)	mber or Rur	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Ce	29a, Certifier 1 Certifying Phys	Iclan: To the best	of my knowledge	death occurred at the	time date and place	e, and due to the	Cause(s) and	manner as	stated.
X	e Hospital of 24 hours at e Funeral C	ledical	(Check only one)	ician: To the best ier: On the basis of and manner st	f examination and/	or investigation, in my	y opinion, death occ	urred at the time	, date and place	e, and due	to the cause(s)
ر	To the I within 2.	Mec	29b. Signature and title of certifier	and mornior of		29c, Lice	nse number		29d. Date sig	ned (Month	Day, Year)
	F > F 0		Manne Mo	rano, MO		Don	065830		ORRIL!	7, 200	8
	241		30. Name and address of person who co		leath (Item 23a) (T						<u> </u>

State Registrar 31. Date filed (Month, Day, Year)

9901 JAMIE R- MORANO, MO 32 Registrar's Signature

MEDICAL CENTER DRIVE, ROCKHILE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 200 Year **Physician** 4:16 PM th SAYbava /Medical give street and numbe 4c. County of Death 4b. City, Town, or Location of Death Apt. 4a. Facility Name (If not institution, Examiner Poplar 7K Hreet arove 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🗸 F Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code Apt. 21216 Grove roplar by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retire(f) Health and Mental Hygiene. Elementary/Secondary (0-12) Coffege (1-4or 5+) rovider 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Unk Be t and 2 should be fi Health and Mental H 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
661 Brisbane Rd., Baltimor, MD 216 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important; If Item 27 is
any Injury or other trau Baltimore, and 21229 JenKins (. Daughter 661 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation Green 3 ☐Removal from State Baltimore, Mount 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see Services, 5151 Balto. Nati Pike 23a. Part1. Enter the clsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (gr as a consequence of): Examiner TIL Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequente of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9☐ Unknown Part II. Other prignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No the Hospital or Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Prip 32 Registrar's Signature 31. Date filed (Month, R 25 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 22 2008 /Medical 4c. County of Death Examiner Pandallstown Ballimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, (State or Foreign 7. Age (Ip yrs. last birthday) **Funeral** Months **M** 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examiner must be notified at once. MD1 Yes 2 No Director Daltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 arver Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired condary (0-12) College (1-4or 5+) Elementary Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12714 Giles Road 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Baltimore, and 21. Sign tur of Funera S rvice Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the dsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due (or as a consequence of): Immunodotraienty /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed burial-transi Due to (or as a consequence of): Box 68760, attending physician pe Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.O. 1 been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 t autopsy performed 2 No this certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H45931 23 2008 nysuccon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD Mainstra

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2 **Physician** 22:50 April 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sina Hospital Bultimore Baltimore 8. Date of Birth (Month Cay, 19ar) 5 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 72 Yrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1**√**M 2□F 219-32-8058 Months Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County at 1 Yes 2 No MD 28a-f shonotified imore Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? must be 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical than College (1-4or 5+) Patient Known ous 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Alda Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, item 27 i b. Place of Disposition cemetery, cremator 20a. Method of Disposition 1 Burial 2 ☐Cremation 3 ☐Removal from State 5 ☐ Other (Specify) of Funeral Service 21. Signatur Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner espirato mont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1∐ Yes 212 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar XCONG.

31. Date filed (Month, Day, Year) APR 2 5 2008 32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month-1:18 AM avor **Physician** 22 JOAN G. SACKALOSKY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Glen Anne Age (In yrs. last birthday) Year) **Funeral** 1 □ M 2 🔀 F 76 212-28-7780 Feb. 29,1932 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 1 ☐ Yes 2 No r 28a-f sh notified Maryland Anne Arundel Glen Burnie Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or U.S.A. 21060 102 Juniper Court ed other than "natural" or items 23a event, the Medical Examiner must be Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural" or iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Maryland 21215-0036 Specify: ۵ م 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Secretary Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Sands Irene M. Leibig ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) (0) permit. Pages 1 and 2 Department of Health a Important; if item 27 is any Injury or other trau 102 Juniper Court, Glen Burnie, Maryland 21060 John J. Sachalosky (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 04-26-08 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens McCarly Poryfrak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VO NOT **Physician** /Medical Due to (or as a consequence of) Examiner 3.1.0 dequentiary not constrors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed 740.25 attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) has been signed by the ge 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 No certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Man of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Ivem 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2008

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otato of Marylan	•	tificate of l	Death	Re	g. No. 2008	3 (353)	
1	Physicia	an	1. Decedent's Name (First, Middle, La			Sm	ith	2. Date of Death	Day JANS	3. Time of Death	
	/Medic	al	Ella 4a. Facility Name (If not institution, gi	Lee			Location of Death	HORIT O	4c. County of Dea	th H	
	Examin	er	100 0 1 1 (1	neral Hosp	ital	Bulton	ore Cir	Ly			
227	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) Co	thplace (State or Foreign ountry) VA	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits	
	Maryla f shoried at	tor	MD NA		Balt	imore			1 X Yes 2 No		
	n the or 28a	irec	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?		
	23a c	ral	2942 Wincheste				216	regify Voc or No.	U . S . A .		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married ※ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∏ No	Specify:	to Rican, etc.)	Black, Whi		
5	72 hou natura lical E	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo		16b. Kind of Business	/Industry	
7	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	l.	omestic		I	Privat	:e	
V	filed v Hygie other t		10th grade 17. Father's Name (First, Middle, Lat			, O.I C.D G.I. C		me (First, Middle, N	Maiden Surname)		
/land	lid be lental rked o	To Be	Joseph Edwards	3			Carrie	Doles			
Mary	nd 2 shoualth and M 27 is mar r traumat		19a. Informant's Name/Relationship Daniel Smith-I		19b. Mailir 2942	ng Address (Street Winche	and Number or R	ural Route Number treet, E	; City or Town, State, Baltimore	Zip Code) e, Md 21216	
e,	of Hea		20a. Method of Disposition 1 1 1 Disposition 3	20b.	Place of Dispo cemetery, cre	sition (Name of matory or other pla	ce)		20c. Location - City o		
Ē	Page ment ant: If		4 ☐ Donation 5 ☐ Other (Spec	cify) Ga:	rrisor	Forest	: Vet 5,	/1/08	Owings Mi	ills, Md	
Baltimore,	permit. Depart Import any inj		21 Sgnatu of Funeral Service Lic	U. Somont	43		ash Ave	, Baltin		21215	
Г			2 a. Part1 Enter the disease, or co shook, or heart failure. List on	mplications that caused the dealy one cause in each line.		/ ,	_ ;		est,	Approximate Interval Between Onset and Death	
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	/Medical Examiner	ı	resulting in deducty	Duy to (SAS a conse	quence of):	HERU.	Disease	0			
à	48	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	wence of):						
/	tificate be executed g physician and as the bunal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1. Diabetes	s rrie	//rtus					
50,	oe execian a	E	resulting in death) Last	Due to (or as a conse	equence or):						
68760,	physic physic the b	edical		d							
Box	± 5 €	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregi 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	су		23d. Date of d Month	elivery Day Year	
O.	at the	Phys	9 ☐ Unknown Part II. Other significant condition		esulting in the u	ınderiving cause gi	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
	w requires that the de been signed by the should be detached	by	Part II. Other Significant condition	5 contributing to document to				1 🗆 Y	res 2 No 3 □	Probably 4 Unknown	
Records,	hystcian: The law requires that the death ce his certificate has been signed by the attendir il director, page 2 should be detached for use	Completed					-··	24a. Was a autop perfor	rmed? 🖊 death	autopsy findings available o completion of cause of ? es 2 \sum No	
Vital		Be C	25. Was case referred to medical examiner?					eath (Check only or	ne)		
	Physic this ce al dire	10	1 ☐ Yes 2 Ø No		ER/Outpatie	III 3 DOA			lence 6 Other (Spoot injury occurred	pecify)	
ou c	ding P	ion:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investiga	28a. Date of Injury (Month, Day Year)		Wo	ork? ☐Yes 2 ☐ No	200. Describe ii	low injury cocurred		
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determin	t be 280 Place of injury - At	home, farm, s cify)	treet, factory, office	•	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,	
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my k xaminer: On the basis of exami and manner stated.	nowledge, dea ination and/or i	ith occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)	
	To the To the Complet	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Mo	onth, Day, Year)	
	F > F 0		1 Hele				8957	3	4/23/00		
	3		30 Name and address of person w	no completed cause of death (It	tem 23a) (Type	Pary/a	nd Gre	neral.	Hospita	l	
	St	ate	31. Date filed (Month, Day, Year) APR 2 5 20	22. Registrar's Sig	pature	Mal					

Physician E11a Mildred /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CN 15TA 1 5. Social Security Number MEDICA 8. Date of Birth (Month, Pay, Year 12/26/1920 7. Age (In yrs. last birthday **Funeral** Hours Months Days Min. 577 28 1□ M 2□ F 8662 87 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State works permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at MD Charles Waldorf Directo 10e. Street and Number 4140 Old Washington Rd 10g, Citizen of What Country? 10f. Zip Code 20602 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ★ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ Xio Specify 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Cashier Retail Services ĭyrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susanna Goldsboro MILDRED Unavailable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3299 Jasmin Ct Waldorf Md 20602 Linda Dias(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Lee Crematory April 22., 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home 6633 Old Alexandria Ferry Rd Clinton MD 20735 21. Signatur, of 23a. Part1. Enter shock, or the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Carse (Findisease or condition resulting in death) Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed the burial-transit and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy

9☐Unknowr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🔲 Inpatient

(Month, Day Year)

28a. Date of Injury

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Reg. No.

2008

14. Race - American Indian

Black, White, etc.

Specify: White

4c. County of Death

HARI

3. Time of Death 12 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

1 ☐Yes 2 No

Washington DC

2. Date of Death

attending physician use as for isigned by the a detached has certificate

P.O. I

Division or Vital Records.

funeral dir

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

Completed

Be

۵

Certification:

Medical

State Registrar

EURC 31. Date filed (Month, Day, Year)

me and address of persor

29b. Signature and title of certifier

9 Unknown

25. Was case referred to medical

2 No

5 Pending investigation

6 Could not be determined

examiner?

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1 ☐ Yes

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)



2 ER/Outpatient 3 □ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

5 Other (specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

08-03063 Joseph Susi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

seph Susi	1-	St. For State	ate of Maryla	and / Depart <i>Certi</i>	tment of <i>ficate of</i>	Health Death	and Menta	ai Hygiei	ne Reg.	No.	20	08 1	353	
Physicia	R	egistrar . Decedent's Name (First, Middl	e,Last)						e of Death		rear r	Time of Death2245 hrs	,	
er Examir		JOSEPH SUS							nth ril 19, 200		ty of Death	2240 1115		
	4	a. Facility Name (if not institution	n, give street and nu	b. City, Tow Baltimor	n, or Location of	Death		4c. Coun	ty of Death					
		University Hospital		t triate days)	If Under 1		24Hrs. 8. D	ate of Birth	MM/DD/YY	YY) 9. Birth	nplace (State or			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)		Days Hours	Littin				Foreign		
Director	2	219-12-6352	1XXM 2 F	83	Yrs	<u>. </u>		INC	00. 10	, 192	-			
1 1 3	-	Usual Residence of Decedent 10a, State 10b, County						10d. Inside City	_					
ow any	- 1	,	Arundel	Anna	polis							1 Yes 2	ΧΧNο	
ih the Maryland 23a or 28a-f show notified at once.	황	AD Anne 10e. Street and Number	71E dildez			10f. Zip Co	ode		. Citizen of	of What Country?				
e Ma or 28 fied a	0	130 Hearne Road	1. Apt. 90)5		21401								
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Me keal Examiner must be notified at once		11. Marital Status	12. Was De	cedent Ever in U.S	6. 13. Wa	as Decedent	of Hispanic Drig	in? (Specify	Yes or No-		ace - Ameri Vhite, etc.	can Indian, Blac	k,	
or item	Funeral	1 Never Married 2 N	Armed I	orces?	II Y				,, 2101,	0	w. Wh	nite	1	
after d	by F		vorced If Yes, Give Ye or Dates:						ione I					
ours a	leted b	15. Decedent's Education (Sp			16a. Deceder during n	nt's Usual Oc nost of working	ng life. DO NOT	use retired)	JOHO					
16 n 72 h	iệ E	Elementary/Secondary (0-12) Grade 12	College	(1-4 or 5+)	Fliah	nt Ins	tructor							
003 withi giene.	타	17. Father's Name (First, Middle	e, Last)				18.Mother			aiden Surn	ame)			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", ' e event, the Me.lkal Examiner.	\circ	Antonio Susi												
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica		19a. Informant's Name/Relation	ship (Type, Print)		4 -4 4									
imore, MD 2 Pages 1 and 2 shoul nent of Health and N iant: If item 27 is n or other traumatic		John Susi /	nephew	100						20c. Local	tion - City or	<u> </u>		
re, l 1 and f Heal f item	- 1	20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Removal	from State	rematory or c	other place)							bale	
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other	Specify:	Oal	klawn				_		CIMOI	c, rarye		
Baltimo permit. Page: Department o Important: injury or oth		21. Signature of uneral Servi	Licensee	_ / M007	70 3	onaids	bott Av	ral Ho	me, P Laure	.A. 1. Ma	rvlan	d 2070	7	
7-48		22a Part February disease	or complications that	caused the death.	. Do not enter	the mode of	dying, such as	cardiac or res	piratory arre	est, shock, o	or heart	Approximate Between Or		
hysician ledical		failure. List only one caus	se on each line.									Dea		
_xaminer		Immediate Cause (Final disea or condition resulting in death)	Due to (or a	s a consequence o	f):									
		Sequentially list conditions,	b											
	iner	if any, leading to immediate		s a consequence o	of):									
	Examiner	(Disease or injury that initiated events resulting in death) Las	Due to (or a	s a consequence o	of):								l	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	<u> </u>	/	d					-						
), be exe sician a	edical	UNPENDED	AMENDE							23d D	ate of delive	erv		
760 icate l	👸	IF FEMALE: 23b. Was decedent pregnant in	1 the 1 Liv	es, outcome of preg ve birth		Fetal death	3 Ector	pic pregnancy	,				Year	
c 68	ciar	past 12 months?	4 Pr	egnant at time of de		Other (Spec	cify)						1	
Records, P.O. Box 6876(The law requires that the death certificate icate has been signed by the attending phy page 2 should be detached for use as the t	Physician/M	1 Yes 2 No 9		known	TO 1 . 16		souss siven in l	Part I	23e. Did t	obacco use	contribute	to the cause of	death?	
ed by 1	by P		e undenying	cause given in	art.		1 Yes 2 No 3 Probably 4 ✔ Unknown							
S, P nires tl n sign d be c	Pa										24b. Were	ere autopsy findings available		
ords w requas been	를									autopsy prior to completion of death?				
Reco	Completed	[1 ✓ Yes 2 No										1 Yes 2 No		
ian: J	Be		lical Hospital:	Inpatient 2	FD/Outnoti		Other			Residenc	e 6 Ot	her:		
· Vit	0	1 ✓ Yes 2 No	- '-		28b. Time			ork2 2	28d Describe how injury occurred					
ding I	;	27. Manner of Death 1 Natural 5 Pending FOUND: 1 Yes 2 ✔ No.							ubject dri ecident	notor veriicie	;			
SiOl Attender death	Sati	2 🗸 Accident	nvestigation Apr	19, 2008 Place of Injury - At	2121 hrs home, farm, s	street, factory	p Code 2 1 4 0 1 Ient of Hispanic Drigin? (Specify Yes or No- iffy Cuban, Mexican, Puerto Rican, etc.) 2 XX No specify: 3 Occupation (Give kind of work done orking life. DO NOT use retired) 18 Mother's Name (First, Middle, Maiden Surnam Loreta Susi ss (Street and Number or Rural Route Number, City or To 1 Timber Lane Bailey, Coldane of cemetery. 20 Address of Facility albott Avenue Laurel, Mary albott Avenue Specify) 23e. Did tobacco use of 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27 And Mary albott Avenue Subject driver of vehi acident 28 Location (Street and Nu rown, State) Route 198 & Route 32, F at the time, date and place, and due to the cause(s) and ma and my opinion, death occurred at the time, date and place, a 29 C. License number O.C.M.E. 1 Penn Street, Baltimbre, MD 21201	Number or	mber or Rural Route Number, City					
Division of Vital Records, P.O. Box 6876 tall or Attending Physician: The law requires that the death certificate is after death. **All Directors.** After this certificate has been signed by the attending physication. The thing of the strength of the st	Certification:	3 Suicide 6 0	etermined (Spe	cify) roadway				R					(/	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I commelety filled in twy the funeral director. page	ے ا		g Physician: To the	best of my knowle	edge, death o	ccurred at the	e time, date and	place, and di	ue to the car	use(s) and i	manner as s	stated.		
To the H within 24 To the F	Medical	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and do to the death occurred at the time, date and place and manner stated.								s, and ddo t		ar)		
Paris P	Me	296. Signature and title of Certifier O.C.M.E. OCME										d (Month, Day, Year)		
										Zhill				
A IN		30. Name and address of person who complete cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
M.		Theodore M. King,		2. Registrar's Signa		-								
	Stat istra		5 2008	2. Registral s Signi	15 19	sade s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment of H rtificate of I			giene Reg. No 2	08	13534
Ì.	Physici	an	Decedent's Name (First, Middle, L.	,					2. Date of Dea Month	ath Day	Year	3. Time of Death
3	/Medic	_	4. F. 19. N		on Irv	ing St	1	Location of Death		18, 20	y of Death	6:50 A M
)	Examin	er	4a. Facility Name (If not institution, g 909 Skyhill Lane		nber)		Odenton			Anne		
	Funeral				7. Age (In yrs.	last birthday)	_ If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl		9. Birthp	place (State or Foreign
Н	Director		216-34-0232	1 ∑ M 2□F	71	Yrs.	Months Days	Hours Min.	11-20-		New New	Jersey
	pu ,		Usual Residence of Decedent		1							
	arylar show d at	-	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits 1 □Yes 2▼ No
	he M 28a-f otiffie	Director	MD Anne A	runde1			Odent 10f, Zip Code	ton		10g. Citizen of	What Cour	
	a or 2						Tol, Zip Code					
	leath ns 23 musi	Funeral	909 Skyhill Lane	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cuba	21113 ispanic Origin? (S	pecify Yes or No-		ed Sta	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Me Acal Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	2 ∏ No		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Rican, etc.)	Speci		etc. nite
Maryland 21215-0036	2 hou atura cal E	ted	15. Decedent's	 Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of B		
215	hin 7%	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1	-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of wor i)	king			
2	ed wit /gien er th	Con		2		Ci	vil Engin				ineer	ing
D D	be file tal Hy doth	Be (17. Father's Name (First, Middle, La	st)				18. Mother's Nan	ne (First, Middle,	Maiden Surna	ime)	
Ya	ould I Men Parker	2	Morris Stei			T			ie Richm			
Nar	12 sh h and 7 is n traun		19a. Informant's Name/Relationship				ng Address (Street) Code)
	1 and Heali em 2		Audrey Steinman 20a. Method of Disposition	/ Wife_	20b. F	Place of Dispo	Skyhill Landstion (Name of	i	Date Mar	20c. Location		own, State
JO L	ages ent of it: If ii		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		matory or other plac el Cremat	i i	10_2008	Ođet	nton	Maryland
altimore,	mit. F partme sortan r Injur		21. Signature of Funeral Service Lice		. 1W•	Al ullu	2. Name and Addre	ss of Facility	Hama (/			
m	a in per	l d	I Marka	Maxle	V мо15	22 1	411 Annar	oolis Roa	d Odento	on. Mar	ry, P yland	21113
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that c	aused the deat ach line.	th. Do not en	ter the mode of dyir	ng, such as cardia	or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		MSTAT	TIC Pa	meneal	ic Can	2012			Sinset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
B,	LXaiiiiiei	_	Sequentially list conditions,	b.	or as a conseq	manes off						
J	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	01 43 4 0011300	quence oi).						
· ·	execun and lateral	Examiner	resulting in death) Last	c	or as a consec	juence of):						
8760,	ficate be executed physician and s the burlat-transit	dical		d								
9	rtifica ng ph	Medi	IF FEMALE:									
Box	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 Feta	al death 3	⊒Ectopic pregnanc	/			ate of deliv	very Day Year
o.	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9□Unkn	ant at time of one	death 51	Other (specify) _					_
Δ.	w requires that the debeen signed by the should be detached		Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to t	the cause of death?
Records,	quires n sign ald be	d by							1 🗆 '	Yes 2 No	3∏ Pro	bably 4 Unknown
000	aw red s bee	Completed							24a. Was		. Were auto	opsy findings available
æ	The lav	mo:							autor perfo 1□ Yes	ormed?	death?	ompletion of cause of 2 ☐ No
Vital	ian: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o			
<u>></u>	hysic this ce	10	1 ☐ Yes 2 DANG			,	nt 3□ DOA Oth	4 LI Nursing F	lome 5 Hesi			ify)
Division or	ing P	on:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Woi		28d. Describe I	how injury occi	urred	
Sic	death ctor: / the	icat	2 Accident investigat 3 Suicide 6 Could not	be 280 Place	of injury - At h	ome, farm, st	reet, factory, office		es 2 ☐ No 28f. Location (Street and Number or Rural Route			
<u>≥</u>	after all Direct of in by	Certification:	4 ☐ Homicide determine	City or Town, State)								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page						th occurred at the ti					
	the Ho in 24 the Fu	Medical	one)		ner stated.	ation and/or ii			urred at the time,	·		
	To 1 To 1	Σ	29b. Signature and title of certifier) (1/		29c. Licens	1.2.		29d. Date sign	10	
			1 hunchos	with to	W. O.	my	D3	8509		upal	18	2008
	15	I	30, Name and address of parson w	relution	11065 L	ittle	PATUXEN	T Ptry	Celum	bis M	1414	2008 hun 21014
Ŷ.	Sta Regist		31. Date filed (Month, Day, Year) APR 2 5 2		legistrar's Sign	arure	and I					

08-03090 Derric Stewar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

rric Stewart		1- F	or State	Sie	ale or iviar	ylalla i	Certi	ificate of	Death	•			R	leg. No.	į	<u> </u>	U 8	135
Physici		1, [iistrar Decedent's Name	e (First, Middle	e,Last)								Date of Dea	Day	Year			of Death O hrs
Exami	an, iner		eric			And:	re		Ste				April 21, 2	2008	. County o	f Dooth		01115
		4a.	Facility Name (in			d number)		4	b. City, Tow Baltimo		ocation of I	Death		40	. County o	Deau	'	1
		L	411 N. Loud			T= .		t Listedovi)	If Under		If Under	24Hrs.	8. Date of B	irth(MM/	/DD/YYYY	9. Bir	thplace	State or
Funeral		1	Social Security N		6. Sex		e (In yrs. las		Months	Days		Min.				Foreig	jn untry)	
Director			17-74-		1X M 2	F	46	Yrs.					12	19	_61_			MD
è			ual Residence of a. State	Decedent 10b. County			10c. City, T	Town or Location	on									side City Limits
ow any		"			_													Yes 2 No
Aaryland 28a-f show 1 at once.	턍	10	MD e. Street and Nu	N.	Α			Baltin	10f. Zip C	ode				109. Cit	izen of Wh	at Cou	ntry?	
e Mai or 28	Director	1	11 Nor	th Lo	ndon A	WA				213	229				Ш	S	A .	
215-0036 // Meeting the death with the Maryland total Hygiene. ** rede other than "natural", or items 23a or 28a-f shorent, the Medical Examiner must be notified at once.	텔	•	. Marital Status	CII DO	12. Wa	s Deceden	t Ever in U.S	S. 13. Wa	s Decedent es, specify	t of Hist	panic Origin	n? (Spe	ecify Yes or N	10-		- Ame	rican Ind	ian, Black,
eath v	Funeral	1	X Never Marri		allieu 1	ned Forces' Yes 2	X No					i donto i	acarr, cro.,				3lac	r.k
fler d	Į Ę	3	Widowed		orced If Yes, Giv	ve Year			Yes 2			and of the	ork dono	16h	Specify: Kind of Bu			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and			29a. Certifier (Check only		Physician: To	the best of	of my knowle examination	edge, death oc n and/or investi	curred at th gation, in m	ne time, ny opini	, date and p ion, death o	nace, ai occurred	at the time,	date an	d place, a	nd due	to the ca	use(s)
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			30. Name and address of person who completed cause of death (Item 23a)															
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08-03057 Paul Shaffer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1- For State 2. Date of Death Time of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 19, 2008 1613 hrs Paul R. Shaffer ¹ Examiner Me 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number Foreign Country)Mary1and Funeral Hours 07/03/1970 Months Days 37 Director 213 02 1659 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 'n 1 Yes 2 X No Glen Burnie Anne Arundel Maryland show 23a or 28a-f sho irector 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number U.S.A. 21061 201 Oakleigh Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? "naturaf", or items Examiner must be 1 Never Married 2 Married Specify: White Yes 1 Yes 2 X No specify: 4 X Divorced If Yes, Give Year 3 Widowed 72 hours after 16b. Kind of Business/Industry à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. Rennie & Clark marked other than c event, the Medical Truck Driver 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Viola Smith Ronald E. Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٥ Glen Burnie, Maryland 21061 201 Oakleigh Avenue Charles Hadel / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 04/24/2008 Cedar Hill Cemetery Donation 5 Other Specify 22. Name and Address of Facility Gonce Funeral Service, P.A 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway become 23a. Part I. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and hysician failure. List only one cause on each line. Death **Aedica** Bronchopneumonia Immediate Cause (Final disease _xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical XUNPENDED physician a AMENSED PII, 27, per ME, g879 5/8/08 TT Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown ģ Division of Vital Records, P. Cocaine use 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of been autopsy death? performed? 1 ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Nursing Home 5 Residence 6 Others Hospital: DOA Inpatient 2 🗸 ER/Outpatient 3 this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural 5 Pending Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Suicide 6 Could not be To the Hospital o within 24 hours af To the Funeral D determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 [2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 21, 2008 O.C.M.E. of person who completed cause of death (Item 23a) 30. Name and address 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 2 5 State 2008 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MFND TTFW/26,28c perPHYS (378,4/25/08 WS) State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician RONALD SHEPHERD ML100451 23 8005 /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL YKESVILLE B WAY 14000 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1**X** M 2□ F Days 72 219 Yrs. MO Director 32 5626 935 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at PASADENa 1 XYes 2 No Director MD HUNE HRUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 DRIVE OREST GLEN 21122 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or Items 23 any injury or other treumatic event, the Medical Examiner must any injury or other treumatic event, the Medical Examiner must any injury or other treumatic event, the Medical Examiner must appear. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 195 Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: δ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION ELECTRICIA 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD SHEPHERN Earl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Allison 3511 21776 San GUINE UR New Windson mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/26/2008 WINFIELD, MD South Carroll Grem 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ZUMBRUN FH & MON CO NE 6028 Road ELDERSBURG MOZIFAY Sykesville 23a. Part Lines the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclematic Cardiovascular years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760, C. or Attending Physician: The law requires that the death certificate be exacuted attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗀 No 1 🗌 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Sister's Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation daath. 1 🗀 Yes 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8005 75 1119 A 00085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1417 MADISON PARK DEINE GLEN BURNIE an 31. Date filed (Menth, Pay Year) 2008 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death I. Decedent's Name (First, Middle, Last) Ам 9:46 George Wendell Saunders April 23, 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F 90 October 17, 1917 Ohio 125-05-6719 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 United States 333 Russell Avenue, #318 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1943–68 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify: Specify: 3⊠Widowed 4□Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government Assistant Commissioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Schaefer Phillip Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Baldwin Lane, Hilton Head Island, SC 29926 Wayne G. Saunders / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 24, 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert A. Fumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenu M01473 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee Wisconsin Avenue, e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failur Immediate Cause (Final 48 Hours Aspiration Pneumonia resulting in death) Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Show r 28a-f show notified at

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Department of Important: If It any injury or o

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending | for use as sign I be page 2 s

Division or Vital Records, P.O. Box 68760,

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To the Hospital or Attending Physician: The law requires that the death certificate be executed filled in by within 24 hou

To the Fune

completely fi 29b. Signature and title of

State

Registrar

edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): c. — Due to (or as a consequence of): d	
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Completed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. the Right Foot	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 1□ Yes 2 No 3 □ Probably 4 □ Unknown
Be (25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)
0	1 ☐ Yes 2 🔼 No		5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)	. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier 1	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. I at the time, date and place, and due to the cause(s)

29c. License number

0064413

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

Juanita Lynn Smith, M.D

APR 25

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

December Name (Print, 1985), 1240 Start Print (1985), 1240 Start Prin				1 - State Registrar	Cei	rtificate of I	Death		F	Reg. No		100	
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The first and the position of	q pin	rked ric e	2	Michael Stavropoulos			Aspa	ısia	Nic	ola	ıou		
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shock of heart failure. List only one cause on each line.) e	8 % %		Tolut Bolow	1	.201 Dun	ıdalk	Ave.	Bal	tim	ore,Md	. 2122	22
Physician (Medical Examiner) Requiringly a condition resulting in death) Due to (or as a consequence of): Condition Due to (or as a consequence of):	20	1		23a. Part1. Enter the dise se, or complications that caused the death.	. Do not ent	ter the mode of dyir	ng, such as ca	ardiac or res	spiratory a	rrest,		Interval Bet	ween
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State St				resulting in death)	ence of):			1			~		
The property of the part of th	Ex	amıner		Sequentially list conditions b.	(Non	Dr=	200	_				
Due to (or also consequence of): d.	(15)	it.	iner	ir any, leading to immediate cause. Enter Underlying	ence of):	,							
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Shoaib A. Hashmi, M.D. 821 North Eutaw Street Baltimore, Md. 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature				1 dell		DO31			_	Apr	il 24,	2008	
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	1892		1. Decedent's Name (First, M.	ddle, Las	st)							2. Date of D Month	eath Day	v Year	3. Time of D)eath
	Physici /Medic		Eleanor C. 7	ravi	is							4	23	2008	n. 40	PM
	Examir		4a. Facility Neme (If not institu	_					. City, Town, c					County of De		
		A 12	FRANKLIN Sou						Under 1 Year	s e da		0.0			more	
0.	Funeral Director		5. Social Security Number 216-20-5443	6. S	ex □M 2√2 F	7. Age ((In yrs. last bii		onths Days	Hours	Min.		Day, Year)	9.8	irthplace (State or a Country)	Foreign
**			Usual Residence of Decedent		Λ							12-6-	-1914		Md.	
	yland		10a. State 10b. Cou	nty			10c. City, Tow	n or Location	on						10d. tnside City	
	e Marie	ctor	Md. Balto				Notti	ngton							1 □ Yes 2	2 X No
	ith th	Olre	10e. Street and Number					1	Of. Zip Code	226			10g. Cit	izen of What (Country? JSA	
	death with the Maryland ms 23a or 28a-f ehow rmat to twilled at	by Funerai Director	4113 Link Ave	nue					212							
3	ltems	nue	11. Marital Status 1 ☐ Never Married 2 ☐ N	larried	12. Was Dec	rces?		13. Was	Decedent of H s, specify Cubi	dispanic Ori an, Mexicar	gin? (Spo n, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - An Black, Wh		
386	urs aff	byF	3 Widowed 4 □ Divor		1 ☐ Yes If Yes, Gir Year or □	veX ates:		1 🗆	Yes & No	Specify:				Specify:	White	
₹ <u>\$</u>	2 hou	Completed	15. Dece	dent's Ed	lucation		16a	Decedent	s Usual Occur	pation			16b. K	ind of Busines	s/Industry	
22	thin 7	npie	(Specify only high Elementary/Secondary (0-1	_	College (1-4or 5+)		life. DO	of work done NOT use retire	auring mos d)	t of work	ing				
27/2	filed wi Hygien other th	Con	7th				R	ivito	r					artins		
A E	be fill H doth	Be	17. Father's Name (First, Midd Charles Blut									ə (First, Middl tina Mu	_			
줊	hould be d Mental narked o	2	19a. Informant's Name/Relati				101	Mailing A	ddrago (Ctmot					or Town, State	Zin Codo)	
9V/S E	od 2 s Ith an 27 le		Mary Mullh					-						. 2123		
> ē	f Heal		20a. Method of Disposition	ause	11		20b. Place o	f Dispositio				Date	_	ocation - City o		
.32	Page: ent o nt: # ry or		Marial 2 ☐ Cremating 4 ☐ Donation 5 ☐ Othe			State	Glen				4-28.	-2008	BR	00/ 440	1 on D:	
a E	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or Items 23a or 28a-f ehow mary injury or other traumatic event, Ite Medical Exacting must be cutflied at once.		21. Signature of Funeral Serv				Gren		Ime and Addre			2000	1/1	-	17.	
	40E 4		> Beens	2	eee			Sch	imunek	Fune	ral I	Home 9	705 B	elair	Rd.	
· j.,		7.	 Part1. Enter the disease shock, or hearf failure. 	or com	plications that one cause on e	aused the	ne death. Do	not enter th	e mode of dyir	ng, such as	cardiac	or respiratory	arrest,		Approximate Interval Betwee Onset and De	een
	Physician		fmmediate Cause (Final disease or condition resulting in death)		a. Re	Na	1 fa	ilui	re						Onset and De	Jail 1
	/Medical Examiner		resulting in dealing	1	Due to	(or as a	consequence	of):	Part	1 6	. 1	212				
		-G	Sequentiafly list conditions, if any, leading to immediate		b. Due to	(b) as a	S//VC consequence	of):	ear-1	TU	1/1	sye				
W	uted d ansit	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	۲												
0,	en an rial-tr	Exa	resulting in death) Last		CDue to	(or as a	consequence	of):						-		
8760,	cate be executed physicien and the burial-transit	Physician/Medicai		•	d	_										
9	entific ling p	Med	fF FEMALE:		00 15											
Вох	attend stend for us	ian/	23b. Was decedent pregnant in the past 12 months?			oirth 2	pregnancy Fetaf death me of death		opic pregnanc	y				23d. Date of d Month	,	ear
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregr 9⊟ Unkn		ne or death	5 🗆 Oti	ner (specify) _		· · · ·					
ص.	Attending Physician: The law requires that the death certific refath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as		Part II. Other significant con-	litions c	ontributing to d	eath but	not resulting i	n the under	lying cause giv	ven in Part I		23e. Did	tobacco i	use contribute	to the cause of de	ath?
rds	quires n sign	d by										1	Yes 2	ØN₀ 3□	Probably 4 □Un	nknown
000	aw require s been si 2 should b	Completed										24a. Wa		24b. Were	autopsy findings av	vailable
æ	sician: The law s certificate has b lirector, page 2 s	E O											opsy formed? 2 No	prior to	autopsy findings av completion of cau ? es 2 \(\sum No	use of
ā	rtifica	Be C	25. Was case referred to med examiner?	ical						26. Place	of Deatl	h (Check only		1	20.10	
>	hysic I direc	To	1 ☐ Yes 2 No		Hospital: 1 🗹	npatient	2 🗆 ER/0	atpatient :	B□ DOA Ott	ner: 4□ Nu	ırsing Ho	me 5 Re	sidence	6 □Other (Sp	ecify)	
D C	ing P		27. Manner of Death 1 ☑Natural 5 ☐ Per	ding	28a. Date (Mon	of Injury th, Day	Year) 28b.	Time of Injury	28c. Injui Wor			28d. Describe	e how intui	ry occurred		
Sio	Attendideath. ctor: A y the fu	cati	2 Accident	stigation]Yes 2 □		00/ 1	(0)	(1)		
Division of Vital Records,	or A after Direction by	Certification:	4 ☐ Homicide det	ermined	build	ing, etc.	y · At home, fa (Specify)	arm, street,	factory, office				own, State		Rural Route Numb	er,
_	spital lours neral filled		29a. Certifier 1 Certi	ying Ph	ysician: To the	best of	my knowledg	e, death oc	curred at the ti	me, date ar	nd place.	and due to th	e cause(s)) and manner	as stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medi	al Éxan	niner: On the b and man	asis of e	xamination ar	d/or invest	gation, in my o	opinion, dea	th occur	red at the time	e, date and	d place, and d	ue to the cause(s)	
	To th To th comp	ž	29b. Signature and little of cer	fier					29c. Licens	se number					nth, Day, Year)	
						- v	ASILIADO	D, M.D.	Do	06479	20.		4	1/23/0	8.	
	4		30. Name and address of pers			so of dos	th (Item 23a)	(Type Prin	t)							
	-		DR MINUS VA	SILI	Ades	90	OO FR	ANKL	n Sac	Lare	- Di	3 Ba	LTIN	1014	md 213	137
	Sta Registr		31. Date filed (Month, Day, Ye APR 2	5 20	08	Ains.	s Signature	Prac	120							
T. A.	2. 4				ALC: NO.	-047 - 13	4.4		ere d							

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Physician /Medical Examiner

death with the Maryland

3altimore, Maryland 21215-0036

Be ဥ Certification: Medical

Division or Vital Records, P.O. Box 68760,

performed? 1∐ Yes 2 No 25. Was ease referred to medical

EO. 1183 CEGO (CIOITO	a to medical					20.	Flace of Deal	ii (Check only one)	
examiner? 1 ☐ Yes 2 No	0	Hospital: Inpatie	ent 2	ER/Outpatient	3 🗆 [OOA Other: 4	☐ Nursing Ho	me 5 Residence	e 6 □Other (Specify,
2 Accident	5 Pending investigation			28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how in	njury occurred
3□ Suicide 4□Homicide	6 Could not be determined		ury - At h c. (Speci	ome, farm, stree	t, fact	ory, office		28f. Location (Street City or Town, St	t and Number or Rural tate)
29a Certifier 1	Certifying Ph	vsician. To the hest	of my kn	owledge death	necurre	ed at the time d	ate and place	and due to the cause	e(s) and manner as sta

(Check only one) 29b. Signature and itte of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D 80 6222 3 29d. Date signed (Month, Day, Year)

2 No

Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAME TO BLANUM, MD 196 TO DRIVE, FLEDERICK, MD -21702

31. Date filed (Month, Day, APR 25 2008



Registrar

al or Attending P after death.

e Hospital on 24 hours affi

To the within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	•	ate of Death	,	Reg.	No.					
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death Month	av Year	3. Time of Death				
dical Exami	ner	Susan A	Thom		and an affine of Dooth	April 18, 200	4c. County of Death	2021 hrs				
		4a. Facility Name (if not institution, give street73 J Ridge Road	and number)	Greenbelt	or Location of Death		Prince George					
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birt			8. Date of Birth (MM/DD/YYYY) 9. Biri	thplace (State or				
Director		228-58-6340 _{1 M 2}	X _F 63	Yrs. Months Da	ays Hours Min.	Dec. 15	, 1944 Foreig	n untry) MN				
ŕ	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits				
ld how a	L	MD Prince Geor	ge's Green	belt				1 X Yes 2 No				
arylar 8a-f s	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cour	ntry?				
the M Sa or 2		73 J Ridge Road		20770		U	SA					
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Funeral		as Decedent Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,				
er dea		3 Widowed 4 Divorced If Yes, G	Yes 2 X No	1 Yes 2 X N	lo specify:		Specify: Whi	.te				
urs aft tural'	d by	15. Decedent's Education (Specify only high	est grade completed) 16a.	Decedent's Usual Occup	ation (Give kind of w		6b. Kind of Business/					
136 hin 72 hou e. than "nat edical Exa	lete	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	during most of working li			D					
15-003(Elled within Hygiene. d other tha	Completed			arehouse Ma			Property M	lanagement				
21215-0036 mid be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exam	Be Co	17. Father's Name (First, Middle, Last) Curtis Eugene Thomps	son		18.Mother's Name Catherin	•	iden Surname)					
Z B B E S	To B	19a. Informant's Name/Relationship (Type, Pri	int) 19	b. Mailing Address (Str	L reet and Number or F	Rural Route Number		e, Zip Code)				
≥ 5±5≡	Ċ	Catherine W. Thompso		107 Skyway								
ore, I s I and of Healt If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Ren	noval from State cremat	of Disposition (Name of o tory or other place)			20c. Location - City or	Town, State				
Page ment c		4 Donétion 5 Other Specify:	Harris	onburg Crem		25/08	Harrisonb					
Baltimore, permit. Pages I am Department of Heal Important: If iten	þ	21. Signature of Funeral Service Licensee	22b	22. Name and Address Maddox Fu	•		W. Main S nt Royal,					
Physician		23a. Part . Enter the disease, or complications failure. List only one cause on each line.	s that caused the death. Do no	ot enter the mode of dyin	ng, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and				
/Medical xaminer	(osclerotic Cardiovascu	ılar Disease				Death				
		b	(or as a consequence of):									
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uted Id ransit	Examine	events resulting in death) Last Due to	(or as a consequence of):									
760, icate be executed physician and the burial - transit	Medical	UNPENDED AME										
760 ficate l g physi		23h Was decedent programt in the	If yes, outcome of pregnancy		3 Ectopic pregna	incv	23d. Date of deliver Month	y Day Year				
Sox 687 leath certifine e attending for use as t	Physician	past 12 months?	December of death	2 Fetal death 5 Other (Specify)	coopic pregne	iiioy	Worth	bay roa.				
Bo ne deat the at	hys	1 Yes 2 No 9 V Unknown 9	Unknown		B-44	Long Did tob	acco use contribute to	the series of death?				
ires that the signed by	by	Part II. Other significant conditions contrib chronic alcoholism	outing to death but not resultin	ng in the underlying caus	e given in Part I.	-		bably 4 🗸 Unknown				
ords, w require s been sig	Completed					24a. Was ar		utopsy findings available				
e law 1 e has b ge 2 sh	idm.	<u> </u>		-		autopsy perform 1 ✓ Yes 2	ed? death?	completion of cause of				
tal Recian: The certificate ector, page	ပို	25. Was case referred to medical		26.Pla	ace of Death (Check		110	65 2 140				
Vita tysicia this ce direct	0 B	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 ER/C	Outpatient 3 DOA	Other Nursir	g Home 5 R	esidence 6 🗸 Othe	er: Scene				
Ing Ph After funeral	on: T	27. Manner of Death	a. Date of Injury (Month, Day,Yeer) 28b.		njury at Work?	28d. Describe ho	w injury occurred					
ivision lor Attendath Birector:	cati	2 Accident Investigation	Be. Place of Injury - At home, f			28f Location (St	reet and Number or R	ural Route Number, City				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lethy filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Certification:	4 Homicide Could not be determined	Specify)	arm, sucet, radiory, one	o ballanig, oto.	or Town, Sta						
	Medical C	one) 2 Medical Examiner:On the	the best of my knowledge, de e basis of examination and/or									
To the within To the comple	Med		anner stated.	29c. Lice	ense number		29d. Date signed (Mo	onth, Day, Year)				
		There 111-1	A Th	0.0	C.M.E. OCME		April 19, 2008					
	Н	30. Name and address of person who complete			D			·,				
le			Assistant Medical Exam 32. Regular's Signature	niner 111 Penn	Street, Baltimor	e, мр 21201						
Si Regis	tate frar	0 5 200	Server D	K Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 13544 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 11:06 PM **Physician** Tate. 18 3008 April James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
May 13, 1967 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Washington D.C. 1 XM 2 - F 218-02-9518 40 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 😿 No Director Maryland Montgomery Potomac 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 11725 Becket Street Funeral Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 [x] No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Kelly James T. Tate, Jr. ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10500 Rockville Pike #1422, Rockville, Maryland 20852 Kelly F. Tate/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park April 24, 20c. Location - City or Town, State 20a. Method of Disposition Rockville, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Nome/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01498 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sepsis days **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Due to (or as a consequence of): obstruction Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed aroli is disease **burial-trai** Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Month Dav Vear in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by or: After this certificate has been signe the funeral director, page 2 should be 1 TYes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2[2 No 1 TYes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 XNo 2 ER/Outpatient 3 DOA ၉ 1 Yes Inpatient Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: At 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number . RES-000 2008 W edical doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

APR 2 5 2008

32. Registrar's Signature

fre Sperie

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 12:25 am Physician 2008 21 Deborah /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** City Baltimore Johns Hopkins Hospi tal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Funeral Days 1 □ M 2 🖼 217-62-696 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ res 2 ☐ No Director Manyland 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatte event, the Medical Examiner must be n Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meals on Wheels Elementary/Secondary (0-12) College (1-4or 5+) Meal Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delores Thomas 19b. Mailing Address (Street and Number or Rural Rouse Number, City or Town, State, Zip Gode) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Cemeter · Carmel 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oximate I rval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** Complicated Urinary Tract Infection /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1 npatient 2 ER/Outpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe John W. Burger, Medical Doctor April, 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W Burger, Johns Hopkins Hospital, 600 Worth Worfe Street, Bultimore, Maryland, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Bev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

13516

			State of Maryland / Department of Health and M Certificate of Death		ienę′ ∪ ∪ _{eg. No.}	0	10040
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h		3. Time of Death
	Physicia /Medica		Sebastiano Joseph Vernali	Month April 1		Year .	3:20 AM
	Examine		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cetion of Death	4c. County of	Death	
			Glade Valley Nursing Center Walkersvi	11e		deri	
152	Funeral Director		5. Social Security Number 049-05-3147 049-05-3147 049-05-3147 05. Sex 1	8. Date of Birth (Month, Day, Mar 16,	^{Year)} 1923	9. Birthpi Count Conne	ace (State or Foreign ry) ecticut
	tand	- 1-	10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	Mary	Š	MD Frederick Walkersville				1 ☐ Yes 2¶ No
	h with the 23a or 28a	Funeral Director	10e. Street and Number 56 W. Frederick Street 10f. Zip Code 21793	1	0g. Citizen of WI USA	nat Count	ry?
020	be filed within 72 hours after death with the Maryland itel Hygiene. Id other than "natural", or frams 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 143-46 13. Was Decedent of Hispanic Origin? (Specify: 15 × specify Cuban, Mexican, Puertor 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White, e	etc.
5-0	72 ho	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work do a during most of working life. DO NOT use refired)	ing	16b. Kind of Bus	iness/Ind	ustry
121	filed within Hygiene. Other than '	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) 10 mechanic		aviat	ion	
b	2 should be filed within end Mentel Hygiene. le marked other than aumatic event, the Mentel than the Mentel th	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name)	
<u>yla</u>	2 should be to end Mentel I to marked of raumatic eve	2	Sebastiano Vernali Angelina				
Mar	s 1 and 2 should f Haalth end Mer Item 27 le marke other traumatic		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Christine Lutz/daughter 19b. Mailing Address (<i>Street and Number or Rure</i> 8304 Jordan Valley Way			State, Zip 217	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 s Department of Haalth er Important: if Item 27 le any Injury or other trau pnce.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)		20c. Location - C		
Balt	pemit. Departi Import any Inj pnce.		21. Signature of Euneral Service Libensee Ronald S. Wade, Director State Anatomy Board Baltimore, MD 2120	1		re S	treet
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock or heart failure. List only one cause on each line.	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical	-	Immediate Cause (Final				1-3-Ws
	E z z viii e r		disease or condition resulting in death) Due to (or as a consequence of):		<u></u>	1	1 3 45
	design.	Je.	Due to (or as a consequence or).			1	
o,	hath certificate be executed attending physician end for use as the bunal-trensit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury				
68760,	cate be physici the bu	dica	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Box 6	eath certifi attanding for use es		d				
	death death	cia	Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use con	tributa to	the causa of death?
P.0	thet tha de ed by the datached	Physician/M		1 □ Y	es 200 No	3 🗌 Prol	pably 4 ☐ Unknown
	ras the	ል	preumona rigper rension		•	0.45 146	
of Vital Records,	The law requires thet the death certifiete has been signed by the attending page 2 should be datached for use e	Completed	Preumona hypertension parkinson Disease	24a. Was a perfor	n autopsy med?	av	ere autopsy findings ailable prior to apletion of cause death?
æ	The law te has	E		1 □ Y	es 2 No	1 🗆	Yes 2□ No
ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	h (Check only or	те)		
Ž	Physician: r this certificantal director,	၉	1 ☐ Yes 2 No Pospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho		ence 6 □Othe		1)
	nding Plath. r: After ti ne funera	ation:	1) Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		ow injury occurre		
Division	s after de of Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Numbe n, State)	er or Rura	l Route Number,
	ne Hospi n 24 hou ne Funer pletely fil	edicai	29a. Certifier (Check only one) Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, 2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred and manner stated.	red at the time, o	late and place, a	nd due to	the cause(s)
	With To th	2	29b. Signature and title of certifier 29c. License number 50060417	4	29d. Date signed		uay, Year)
			() () () () () () () () () ()	F			21702
			31. Date filed (Month, Day, Year) 32. Projector's Signature	rved	evice	MD	21102
*	Stat Registra		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hence Shah Go Thomas Johnson Dr 31. Date filed (Month, Day, Year) APR 2 5 2008 APR 2 5 2008				
		_					

DHMH 16 Rav 6/95

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Hyattsville MD. P.G. Directo 10e. Street and Number 10f. Zip Code 20781 4922 LaSalle Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Cuban Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hat Maker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other this any Injury or other traumatic event, the once. 12th 17. Father's Name (First, Middle, Last) Be unavail 19a. Informant's Name/Relationship (Type. Print) Peter Rios/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/08 Mt. Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee n Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYELOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown led by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be c Completed by has page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNE MD 4203 Queensbong Rd Hyattsville DE 31. Date filed (Month, Day, 🚀. Registrar's Signature State

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 1 **4** Velazquez Belkis 2008 6:00 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death P.G. Hyattsville St Thomas More Nursing Rehab. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 6. Sex Days Hours 1 M 2 X F Cuba 69 3-15-39 060-36-0433 Usual Residence of Decedent 10d. Inside City Limits 1 XYes 2 □ No 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Specify: Hispanic 16b. Kind of Business/Industry Private 18. Mother's Name (First, Middle, Maiden Surname) Ana Garcia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Dayton St. Elizabeth, N.J. 07202 20c. Location - City or Town, State Washington, D.C. Packett's Funeral Chapel, Inc. 814 Upshur Street, N.W. 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2645 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Other: 4 Wursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

APRIL 14 2008

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, 2. Date of Death Month 9:30 € **Physician** වූවී, 150n 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore tospice te or Foreign **Funeral** Months 1 □ M 2 🔀 Yrs 09.04. Director 10a. State City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at Blen Burnie 1 XYes 2 □ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 2106 Funeral . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ひのK ltimore Mother's Name (First, Mide 17. Father's Name (First, Middle, Last, To Be Glen Burnie, MD tusband 21061 Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of Important; If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funera Service License 21229 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart alture. List only one cause on eyn lin Approximate Interval Between Onset and Deatl Immediate Cause (Final **Physician** resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, 3 ☐ Probably 4 Onknown 1 ☐ Yes 2 □ No Completed 4b. Were autopsy findings available prior to completion of cause of death?

1 ☐ es 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Montil, Day, Year) 29b. Signature and title of certifie State 25 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per dr., 8878, 04/24/08dlb 23a Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 3:42 PM **Physician** WILLIAMS Apri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Maryland Medical Center Iniversity of 8. Date of Birth Moral Pari 20 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 😿 F 220-24-5900 Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a State 1 Mes 2 No timore tonsv: 11e by Funeral Director 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education fy only highest grade completed) College (1-4or 5+) dary (0-12) ure Middle, Majden Surname) Be Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) 3 ☐Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healf-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Agonal Aspiration 2 Hours Physician /Medical Due to (or as a consequence of): Stroke Examiner 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 TYes after death.

I Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1□ Yes 2►No 1☐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. P 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Room N3E09 Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

Cindy Lee

31. Date filed (Month, Pay, Year) APR 2 4 2008

39 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🖯 🕕 🖰 Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer 9:00 AM **Physician** Inslow naclotte. 3008 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Carrol1 Fairhaven Retirement Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan 12, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 013-14-8038 1 ☐ M 2 🖾 F 90 New Jersey Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Haaith and Meniel Hyglane. Important: If item 27 is marked other then "neturel", or iteme 23e or 28e-1 show eny injury or other treumatic event, the Medical Examinal must be notified at abser. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD 1 ☐ Yes 2√2 No Carrol1 Sykesville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7200 Third Avenue 21784 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Oliver Knapp Gertrude Rose Conkling P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1224 Clearfield Circle Lutherville, MD Patricia Funderbunk/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Consee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes Physician Myocardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physiclen end use es the buriel-trensit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 THO 1 Inpatient 2 ER/Outpatient 3 DOA his hours efter deeth. Ineral Director: After this y filled in by the funerel di 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours of To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Read Eldershus MD 21784 1645 Liberty 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23 3008 DRI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 508 Lutherville 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral (Month, Day, Year) 10/23/1927 Days Min Months 1 □ M 2 Z F 80 Vrs 216-20-4243 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at Lutherville 1 ☐ Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21093 508 Hilltop Drive America of Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. illed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 3√∑No 2 3X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Baltimore Orioles Book Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H Roy Blankenship Margaret Tyree t and 2 should be Health and Ment ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 508 Hilltop Drive Lutherville, Maryland 21093 Margaret Heyl/ daughter item April 25, 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVAILS FUNCTAL 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4☐Donation 5☐Other (Specify) Chapel - Bel Air Forest Hill, Maryland ral Service Licensee 21. Signatu 22 Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRONEHOGENIC CARCINOMA 10 years Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter United ying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed use as the burial-transi 1 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown The law requires that the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by ALZHEIMER'S 1 Yes DISCHSE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

SCRENA R. NOLAN, MD 31. Date filed (MoAIPR 25 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

8813 SATYL HILL RD #100 BACFIMORE, MD 21234

DO025010

april 24, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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·	Funeral Director		5. Social Security Number 566–62–4790	6. Sex 1 X M 2 □ F	7. Age (In yr 67	s. last birthday) Yrs.			ours Min		Sirth Day, Year 194	9. Birth Cou	pplace (State or Foreign Intry) LA	
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Maryland 21215-0036	Tand 2 sho Health and tem 27 is ma		19a. Informant's Name/Relations Belinda Wal	hip <i>(Type. Print)</i> ker / Wi	fe							or Town, State, Z		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		1 State	Place of Dispo cemetery, cre covidence			4/2	Date 8/2008	20c. L	ocation - City or T		
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68760,	ate be executed hysician and the burial-transit	dical Examiner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	equence of):									
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/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examine?					26.	Place of De	ath (Check only				
7	is din	10	1 Pres 2 No			ER/Outpatier			Nursing	Home 5 ☐ Re	sidence	6 □Other (Spec	ify)	
ion	Attending Pr r death. ector: After th by the funeral	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	9 '	e of Injury nth, Day Year)	28b. Time of Injury		Injury at Work? 1 □ Yes	2 □ No	28d. Describe	e how inju	ry occurred		
Division or Vital Records,	il or Atte after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Plac	e of injury - At ding, etc. (Spec	home, farm, str	eet, factory, of	fice		28f. Location City or T	(Street a.	nd Number or Ru e)	ral Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 ☐ Certifyin 2 ☐ Medical	g Physician: To th Examiner: On the and ma	e best of my ki basis of examin	nowledge, death	h occurred at to vestigation, in	ne time, da my opinior	ate and place n, death occ	e, and due to the	e cause(s e, date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifie	>=			29c. Li	cense num	ber		29d. Da	ate signed (Month	, Day, Year)	
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		+ 300 R	16			D	403	24			21L 21,0		

State

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 ROAD,

CLINTON, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RERRY JODRIE, MD 7503 SURRATIS

31. Date filed (Month, Day, Year)

32 Registrar's Signature

08-03028 Christopher Was		Please Type or Print in Black Indelible Ington State of Maryland / Department of Certificate of Certificate	Health and Mental Hygiene	e 2008 (3554									
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Christopher Washington	2. Date	Reg. No. of Death 18, 2008 A 3. Time of Death 1537 hrs									
*			4b. City, Town, or Location of Death Bel Alton	4c. County of Death Charles									
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 45 Yrs.	Months Days Hours Min. 12/	e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) PA									
ow any		Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 Yes 2 X No									
ne Maryland or 28a-f sh	Director	10e. Street and Number 8935 DuPont Blvd.	10f. Zip Code 19960	10g. Citizen of What Country? USA									
Baltimore, MD 21215-0036 Pearin. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes 2 No If Yes Give Year or Dates:	s Decedent of Hispanic Origin? (Specify Yeses, specify Cuban, Mexican, Puerto Rican, e	Specify: White									
036 ithin 72 hours ne. r than "natuu	Completed	Flementary/Secondary (0-12) College (1-4 or 5+)	it's Usual Occupation (Give kind of work don ost of working life. DO NOT use retired) ilermaker	16b. Kind of Business/Industry Construction									
21215-0 Ild be filed w Mental Hygie narked other event, the N	To Be Cor	17. Father's Name (First, Middle, Last) George Washington, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	18. Mother's Name (First, M Sarah D.										
e, MD 2 1 and 2 show Health and I fitem 27 is retraumatic		Sarah D. Washington / Mother 8935 I	DuPont Blvd., Lincol sition (Name of cemetery, her place) Date	n, DE 19960 20c. Location - City or Town, State									
laltimor rmit. Pages spartment of rportant: II		1 X Burial 2 Cremation 3 X Removal from State Milford Condition 5 Other Specify: Cemeter 21. Signature of Euneral Service Licensee 22. N	Name and Address of Facility	ms Funeral Home Inc.									
Physician /M dical xaminer	Examiner	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of):											
760, icate be executed physician and the burial - transit	Medical	events resulting in death) Last d. X UNPENDED AMENDED AMENDED #23a,27,28a-f, perME,g87 23c. If yes, outcome of pregnancy 23b. Was deposed to pregnancy		23d. Date of delivery									
Division of Vital Records, P.O. Box 68760, rother Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician	past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	etal death 3 Ectopic pregnancy ther (Specify)	Month Day Year Se. Did tobacco use contribute to the cause of death?									
IS, P.O. B quires that the d en signed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the u	1	Yes 2 No 3 Probably 4 Vunknown Ia. Was an 24b. Were autopsy findings available									
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	Completed		1 26.Place of Death (Check only one	autopsy performed? PYes 2 No 1 Pyes 2 No									
Vital hysician: this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	t 3 DOA Other Nursing Home	e 5 Residence 6 Other: Scene									
Division of ¹ To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to ompletely filled in by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending Investigation Processing Street Processing	1 Yes 2 X No U	nk cation (Street and Number or Rural Route Number, City									
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	ပ	Suicide 6 X Could not be 4 Homicide determined (Specify) found in motel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	room 9295 urred at the time, date and place, and due to										
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated, 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	O.C.M.E. 111 Penn Street, Baltimore, MD	April 19, 2008									
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature		21201									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** April 21, 2008 3:47 A Wilber Frank Wilson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1**☑** M 2□ F Apr. 17, 1937 Georgia Director 219-34-9273 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notifled at 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland | Harford <u>Joppatowne</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 21085 715 Joppa Farm Road USA ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify ð 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than "n traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Co-Owner Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilber Herman Wilson Nancy Elizabeth Knight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trat once. 715 Joppa Farm Road, Joppatowne, MD 21085 of Disposition (Name of Date 20c. Location - City or Town, State Joanne Wilson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-23-08 4 □ Donation 5 ② Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral 3-ryio 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part L Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Tract Infection Examiner Dus to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) attending physician or use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy actio 1 Yes 2∏No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

ve Hospital or Attendi 124 hours after death. ne Funeral Director; f within 24

with the Maryland

State Registrar

DHMH 17 Rev 1/2001

30. Name and

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&8 Per FH G879 5/01/08 JH Reg. No. 3. Time of Death 2. Date of Death $\overset{\text{Day}}{\underline{16}}$ 1. Decedent's Name (First, Middle, Last) Year 08 **Physician** 2145 04 Williams Gene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland WMHS Braddock Campus 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ♣M 2 ☐ F New 39 June 18,1968 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marylas 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces? 2 No Blac 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Şecondary (0-12) College (1-4or 5+) unemploye Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 is marked other Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gene Williams YIVIA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. roximate erval Between set and Death Immediate Cause (Final & DAYS PNEUMONIA **Physician** disease or condition resulting in death) /Medical QUIRED IMMUNO DEFICIENCY SYNDROME Examiner Sequentiary list currents, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ️ To 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1[Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Injury 5 Pending investigation Natural in 24 hours after where the Funeral Director: After an interest filled in by the funeral directors and the funeral directo 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APRIL 16, 2008

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (item 23a) (Type, Print)

A. William Lamm 900 SETON DRIVE 32 Registrar's Signature

Cumberland, ND 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 6:59AM **Physician** Williams Beatrice 2008 April /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAltimore Agnes Hos p.ta 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) Mayland . Age (In yrs. last birthday) Yrs. 5. Social Security Number **Funeral** Days Months Hours 1□M 2□4 -1023 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 les 2 No Director Marylan 10g. Citizen of What Country? 10e. Street and Number 4233 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after di If Hygiene. other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 ₩idowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemakes permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mac Otho 19b. Mailing Address (Street and Numbe 19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code, 4233 Idon Vand Igens daugister 20a. Meth Disposition City or Town, State 20b. Place of Disposition (Name of 20c. Location -1 Veurial 2 Cremation 3 Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee Mar TMON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a nonsequer reloft Examiner use as the burial-transit this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2 □Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be-Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 2 0 No 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 1 Yes 210 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 312 OA 1 Innatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital

within 24 hours a To the Funeral C

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of pertifier

29a. Certifier

31. Date filed (Month, Day, Year, APR 2 5 2008

S. Cakon Ave

. Registrar's Signature

H62862

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

April 22, 2008

Baltimore, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Zinsavage 14:40 PM 2008 ette 23 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Hopkins Baltimore Bayview Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Months Days Hours 1 M M F 44 215-56-4989 December 26,1963 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 □Yes 2XINo Dindalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21222 1801 Towson Avenue Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Crossing Guard 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Teresa L. May Arthur B. Kettell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1801 Towson Avenue, Dundalk, Maryland James Zinsavage Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Aprilate 26, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Sanature of Funeral Service Licenses 22 Name and Address of Facility Lone of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): if yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 2 □ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medica Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-transit and ed by the attending physician detached for use as the buria director, page 2 should peen this funeral After within 24 hours after death To the Funeral Director: filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

death.

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed

resulting in death) Last IF FEMALE: 1 ☐ Yes 2 ☐ 9 ☑ Unknown 3 ☐ Suicide 4 Homicide

Certification: To Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident

29a. Certifier

(Check only one)

29b. Signature and title of certifier

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

1 npatient

Hospital:

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

1□ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)

Ruan Kretzer M.D. 4940 East

Ryan Kretzer Eastern Avenue Baltimore MD

31. Date filed (Month, Day, Year) State Registrar 25 2008 32. Registrar's Signature

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:00 A M 21, 2008 APRIL GENEVIEVE MARGARET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🛣 F Director March 5, 1925 West Virginia 83 <u>230–32–6755</u> Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 115 Fern Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: \$ White 3 ☐ Vidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Kathern Dettinburn Walter Clarence Dayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5306 Holniker Drive, Sykesville, MD 21784 Deborah Z. Cooley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Baltimor 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 4-24-08 Bel Air, MD 4 ☐ Donation S ☐ Other (Specify) 21. Signature Funcial S McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) physician requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown bed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was a autopsy performed Yes 2 No certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Mooco39070 o. W ۵ ENEVI B Hospital or Attending Physician; within 24 hours a

> 10 State

DHMH 17 Rev 1/2001

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 25 2008

determined

Name and address of person who completed cause of death) (Item (23a) (Type, Print) SQO Upper Chlsoplake Drive Unnifer M. Bontrod Belair, many land

Date filed (Month, Day, Year)

3. Registrar's Signature

4 Homicide

(Check only one)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

MDHOUGUSS

29d. Date signed (Month, Day, Year)

121/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 | 3560 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar		Certific	ate of	Death					Reg. No)			
Physicia	n/	1. Decedent's Name (First, Midd Mary Ann Al								Date of D	Day	Ye	аг	3. Time of De 1637 hr	
edical Exami		4a. Facility Name (if not institution			4	b. City, Tow	n, or Lo	ocation of		April 5,		c. County	of Death	L	
		1470 Bay Green Drive	_			Arnold						Anne A	rundel		
• Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last bir	rthday)	If Under	Year Days	If Under Hours	Min				Foreig	rthplace (State	
Director		472–36–8422	1 M 2 X F	74	Yrs.	MOTUTS	Days	riours	IVIII I.	Jan.	22,	1934	Co	ountry Minn	esota
à.	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location	on								10d. Inside (City Limits
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arylan 8a-fsi atono	Director	10e. Street and Number				10f. Zip Co				_	10g. C	itizen of W	hat Cou	ntry?	
the Man or 2		1470 Bay Green	n Drive					2101	2			U.	S.A.		
72 hours after death with the Maryland n "matural", or items 23a or 28a-f show any af Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 N	12. Was Decedent Armed Forces?			Decedent es, specify (No-		e - Amer te, etc.	rican Indian, B	lack,
ter dea			1 Yes 2 vorced If Yes, Give Year	X No	1	Yes 2X	No	specify:				Specify:	·	hite	
ours afi etural	d b	15. Decedent's Education (Spe	or Dates:	ppleted) 16a	. Decedent	's Usual Od	cupatio	n (Give ki			16b	. Kind of B	usiness	Industry	_
6 372 hc 881 "ns	lete	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	auring mo	ost of workin Owne	_	JO NOT U	ise retiret	1)	,	Shoe	Tndi	ıstrv	
5-0036 led within Hygiene. other tha	Completed	17. Father's Name (First, Middle						3.Mother's	Name (F	First, Midd		en Surnam			
215. Se filed Ital Hy ked of	Be C	John McNeely	, 2001)					Mae	Car	lin					
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than	P	19a. Informant's Name/Relation Kevin Alviani		19										e, Zip Code)	il.
MC 2 slath ar em 27 rauma		20a. Method of Disposition	-/5011	20h Place		ition (Name				apo11				21403 r Town, State	
Baltimore, MD 21215-0036 pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mould be filed within 72 hours after Important: If item 27 is marked other than "natural", injury or other traumatic event, the Mocked Examine:		1 X Burial 2 Crematic	n 3 Removal from Sta	crema	atory or oth						- 1		•	lle, M	D
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Balti permit. Departm Imports injury o		Toda	E Rile	w	147	7 Duke	of	Glo	uces	ter S	st.,_	Anna	poli	s, MD	21401
Physician		23a. Part I. Enter the disease, of failure. List only one cause		the death. Do r	not enter th	ne mode of	dying, s	uch as ca	rdiac or r	espiratory	arrest, s	shock, or h	eart	Between	onset and
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760, ficate be executed g physician and the burial - trans	Medical	UNPENDED	AMENDED 23c. If yes, outcor	mo of programs							- 1	23d. Date	of delive	erv	
	an/N	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live birth			tal death	3	Ectopic	pregnan	су		Month		Day	Year
atter or us	/sician/	1 Yes 2 No 9 ✔ U		time of death	5 Ot	her (Specif	y) _				. (4				
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of Vital Records, ng Physician: The law require the this certificate has been si neral director, page 2 should t	ြ	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		Outpatient Time of I			y at Work		Home 5		injury occi		er: Scene	
nding nding rth.	ion	1 Natural 5 Pe	Apr 5, 2008		37 hrs			es 2 🗸	19	Subject					
Division tal or Attendi rs after death. ral Directors /	fical		estigation 28e. Place of Ir	njury - At home,	farm, stree	et, factory,	office bu	uilding, etc	c. 2		on (Stree		nber or F	Rural Route No	umber, City
E 5 5 E 1	Certification:	4 Homicide det	ermined (Specify) Sir							470 Bay	Green	Drive , Ar			
= 3 = 21	edical (29a. Certifier 1 Certifying Check only 2 Medical Ex	Physician: To the best of maniner:On the basis of exa	ny knowledge, d mination and/o	death occur	rred at the t	me, dat	te and pla death occ	ce, and c	tue to the	cause(s) date and	and manr place, and	ier as st d due to	ated. the cause(s)	
To the within 7 To the complete	Medi	29b. Signature and title of certification	and manner stated.					number						fonth, Day, Yea	ar)
		his his	nv.P				0.C.N	л.E.			Α	pril 6, 2	800		
		30. Name and address of person	n who completed cause of												
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S Regis		31. Date filed (Month, Day, Year	32. Registra	ar's Signature	. 1	and .	,								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 2. Date of Death 3. Time of Death Dededent's Name (First, Middle, Last) Year 08 FERIAT 04 0930 M 07 ANE 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Anne Arundel Annapolis Riva Terrace II Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) Social Security Number 6. Sex Months Days Hours 1 M 2 KF Algeria 12/12/1923 84 222-32-6850 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 2707 Riva Rd. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No White f Yes, Give rear or Dates: Specify Specify: 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retai1 Salesperson 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isaac Aferiat Clara Nakam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 263 Beach Ave., Staten Island, NY 10306 Maryse Karsenty/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD 4/8/08 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 21. Signal Professional Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mille 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not, inter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on expline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death Check onl one Terroa Other: 4 Nursing Home 5 Residence 6 Other Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28c. Injury at Work?

Physician /Medical **Examiner**

and

attending physician

the

signed by

has been

certificate

After this

within 24 hours after death To the Funeral Director: completely filled in by the

death.

or Attending Physician:

To

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

permit. Pages 1 am Department of Heal: Important: If item 2 any Injury or other

Physician

/Medical

Examiner

Funeral

Director

Examiner must be notified

other traumatic event, the Medical

Director

Funeral

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Completed

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2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt; If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-tran the use as for þ page 2 should be Completed funeral director, Be

Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknow

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated.

29c. License number

1 ☐ Yes 2 ☐ No

who completed cause of death (Item 23a) (Type, Print)

MAM

29d Date signed (Month, Day, Year)

Registrar

Medical

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

1 Natural

2 Accident

(Check only one)

3 ☐ Suicide 4 Homicide

29a. Certifier

APR 1 0 2008

5 Pending investigation

6 ☐ Could not be

М

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:40 PM 2008 William Edman Ayers 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1, 2) Washington County Washington County Hospital 9. Birthplace (State or Foreign Country) 1931 West Virginia 7. Age (In yrs. last birthday) Year) Sex 1XDM 2□F 77 March 16, 233-44-1547 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 ☐ No Shepherdstown Jefferson county Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 25443 336 Steamboat Run Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Grocery Store Corp. Human Resources Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Verta Edman William J. Ayers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 142 Southern Oak Dr. Hagerstown, MD 21740 Janet Rice Gilotti-friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 4-14-2008 Smithsburg Crematory 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaitlin 23a. Part1. Enter the disease, a com/lil ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acul Due to (or as a consequence of): OYIC as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 2□ No

1 Yes

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

and

Important: If it any injury or o orice.

Physician

/Medical

Examiner

10a. State

West

Directo

Funeral

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Completed

Be

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Funeral

Director

Show r 28a-f show notified at

ral", or items 23a or Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine

Baltimore, Maryland 21215-0036

death

as the detached funeral filled in by

Hospital or Attending Physiclan: The law requires that the death certificate be executed

After this

after death

within 24 the

completely

Division or Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physiclan/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L þ Be Completed performed 1∐ Yes 2 PNo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

05H-12

State Registrar

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) WATERD 31. Date filed (Month, Day, Year)

APR 1

29b. Signature and title of certifier



Slussay



29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician EDWARD** ADKINS 2608 CLARENCE /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Regional medical eningula 8. Date of Birth (Month, Day, Year) Mar. 22, 1933 Age (In yrs. last birthday Security Number **Funeral** Days Hours Months Min. 1 1 M 2 □ F 75 214-30-8971 Director Usual Residence of Decedent Adding 214-30-8971 10c. City, Town or Location 10a. State r 28a-f show notified at death with the Marylan Westover Directo Maryland | Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n 21871 29263 Kingston Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TXYes 2 □ No 1950— If Yes, Give Year or Dates: 1954 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Internot of Health and Mental Hygiene. It item 27 is marked other than "natural", or Ite may no other traumafte event, the Medical Examine. my or other traumafte event, the Medical Examine. 1 ☐ Never Married 2 X Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 1954 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Brush Mfq. Maintenance 10 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Edward Adkins Freida Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 29263 Kingston Lane - Westover, MD Doris M. Adkins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State American Legion Cemetery 4/12/08 Crisfield, MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Interstitic! /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

426

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 ☐ No

1 ☐Yes 217 No

Maryland

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 00 533 94 Name and address of person who completed cause of death (Item 23a) (Type, Print) INE. roll 50 Anthony 31. Date filed (Month, Day, Year) APR 1 1 State 2008 Registrar **ORIGINAL**

08-02720 Gloria Lova Arvin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

loria Lova Arvin		State of Maryland / Department of Heal For State Certificate of Deat		Reg. N	200	18 356
Physician	_	gistrar Decedent's Name (First, Middle,Last)		Date of Death Month Day		3. Time of Death
ledical Examine		Gloria L. Arvin	Town, or Location of Death	April 6, 2008	4c. County of Death	1820 hrs
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Funeral	5	Coolar Coolar y Hamber	er 1 Year If Under 24Hrs	_	M/DD/YYYY) 9. Bir Co	thplace (State or Foreign untry)
Director	2	34-44-6377 1 M 2XF 76 Yrs. Montr	ns Days Hours Min.	May 16,		t Virginia
any	_	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* .	_ N	Maryland Frederick Knoxville				1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	1	De. Street and Number 10f. Zip	Code	10g. 0	Citizen of What Cou	ntry?
th the N 23a or notified	<u> </u>	831 Point of Rock Road	21758	if -V No	United S	tates ican Indian, Black,
™ sa a		Nover Married 2 Afortied Armed Forces? If Yes, speci	ent of Hispanic Origin? (Sp lfy Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	ican mulan, black,
		as Detect	No specify:			hite
nours aft		during most of wo	Occupation (Give kind of working life, DO NOT use reti	work done 16 red)	b. Kind of Business	Industry
hin 72 hours afte e. than "natural"; edical Examiner	Completed	College (1-4 or 5+) 6 Mail (lork	,	Jational (Geographic
21215-0036 ould be filed within 7 Mental Hygiene. I Mental Hygiene is marked other than ic event, the Medics	5 -	7. Father's Name (First, Middle, Last)		(First, Middle, Maid		SCOGIAPHIC
1218 arked svent, 1	e .	oseph Wilt	Anne E.	Dillow	City or Town Stat	e Zin Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. It item 27 is anaked other than "natural", or other traumatic event, the Medical Examiner.	- (Tender Lane			3.74
e, N I and 2 Health item 2	- [7	0a. Method of Disposition 20b. Place of Disposition (Na	me of cemetery,	Date 20	c. Location - City o	r Town, State
MOC Pages lent of ant: 16	- 1	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Fairview Ceme	l	0/2008 I	Bolivar,W	est Virginia
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 2.7 is an injury or other tranmatic.		1 Signature of Fineral Service Licensee	d Address of Facility Fer Funeral I Doossumtown I	Homes P. A	Α.	
Physician	- 1	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode) possumtown I of dying, such as cardiac	or respiratory arrest,	lerick, M shock, or heart	Approximate Interval
/Modical		failure. List only one cause on each line mmediate Cause (Final disease a. Intracerebral Infarct				Between Onset and Death
'xaminer		or condition resulting in death) Due to (or as a consequence of):				
	<u>.</u>	Sequentially list conditions, f any, leading to immediate b. Due to (or as a consequence of):				
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8760 tificate b	Ž 2	F FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3 Ectopic pregn	ancy	23d. Date of delive Month	Day Year
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that the der	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
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ords,	Completed by			24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Recc The lay cate ha	E			performe 1 Y Yes 2	promoted pro	
/ital Rec	8	25. Was case referred to medical examiner? Hospital: 1 Ver 2 No. 2 Reference 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check DOA Other; Nurs		esidence 6 Oth	ner:
of Vi	위	1 V Yes 2 No Propagation 22 Exodupation 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
ision of ' Attending Ph ar death. rector: After 1 by the funeral	[랿	Natural 5 Pending	1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral directory.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.	28f. Location (Street or Town, State		Rural Route Number, City
Divis ospital or A hours after uneral Dire ly filled in b		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at t	he time date and place ar	d due to the cause(s	s) and manner as st	ated.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Medical	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred at to one) Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred	at the time, date an	d place, and due to	the cause(s)
	Š		9c. License number		29d. Date signed (A	fonth, Day, Year)
		(likelly)	O.C.M.E.		April 7, 2008 	
10		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD, Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 21	201		
Sta	ite	31. Date filed (Month Charles) + COOO 32. Figistrar's Signature	9			
Registr	аг	APR I' 1 2008 Blow or Agence	År.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day O3 Year 08 2200 M 04 AID 15 ou CH EUE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Harwood Mandarin Hospice House If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours ŃC 246-17-5963 43 10/26/1964 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □ Yes 24 X No Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20711 USA 279 Ella Welch Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 X Poivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Edna Call Odell Mastin Bouchelle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2275 Fishing Creek Arbor Rd. Wayne Bouchelle Brother Wilkesboro, NC 28697 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/8/2008 North Wilkesboro, NC Mountlawn Mem. Park 21. Signature of Furnaral Septice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, mD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 WC FAILURE Immediate Cause (Final

Physician /Medical **Examiner**

Physician

/Medical

10a. State

MD

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show sdical Examiner must be notified at

traumatic event, the Medical

Department of Health ar Important: If Item 27 Is any Injury or other trau

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ģ Be Completed Medical Certification: To

disease or condition		2
resulting in death)	Due to (or as a consequence of)	ylan
Sequentially list conditions, if any, each of the cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
		. Was an autopsy performed? Yes 2 2 0 0 1 1 Yes 2 0 No
25. Was case referred to medical examiner? 1 ☐ Yes 2 No	26. Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	only one) Residence 6 Spiner (Specify) HOUSE
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	cribe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e, Place of injury - At nome, farm, street, factory, office 28f, Loca	tion (Street and Number or Rural Route Number, or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	
	200 License sumber	20d Bata signed (Manth Day Vana)

State Registrar 31. Date filed (Month, Day, Year) APR 0 8 2008

30. Name and address of p

Name and address of person, who completed cause of death (Item 23a) (Type, Print)

I CHAEL J. La ENTAM 445 DETENSE HIGHWAY ANNAPOLIS 32. Segistrar's Signature

08-03097 Ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

2008 13566

_	- For State			tificate of D	reauri			Reg. N	D.		
Physician/	tegistrar 1. Decedent's Name (First, I	Middle,Last)					Mont	of Death	/ Year		. Time of Death 1041 hrs
Examiner	Carol Huc	nhes Blar	nchard					19, 2008	4c. County o	of Death	
2	4a. Facility Name (if not ins	titution, give street a	and number)		City, Town, or	Location of D	eath		Dorches		
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cto litera	10e. Street and Number				10f. Zip Code			109.		nat Count	
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두 드 '' #	Terry Jo H		sister	. Place of Disposit	tion (Name of c	emetery.	Date	7			Town, State
s I and 2 s of Health a If item 27 her traum	20a. Method of Dispositio	n emation 3 Re	moval from State	crematory or oth-	er place)		4/22/0	.	Cali	chur	y, MD
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permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	21. Signature of Funeral	Service Licensee			ame and Addre					ome 1613	P.A.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4-21-2008 2:30 A Naoyo Bradley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 455 Carrollton Drive 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral 1 □ M 2 T F 510-44-1292 74 Director Japan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is "selfer Exprise in all to in filling any injury or other traumatic event, is "selfer Exprise in all to in filling any injury or other traumatic event, is "selfer Exprise." Yes 2 □ No Director MD Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 455 Carrollton Drive 21701 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: چ و 3 N Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ Airpax Inc. Assemb1v 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hanako Matsuoka Naoske Matsuoka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Bradley Daughter 101 Council Drive Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State Smithsburg 4-26-2008 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church St. Frederick MD 21701 M01176 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. te Cause (Final NON-SMALL CELL LUNG CANCER 1/2 YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of: Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate has page 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

3altimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

D31761

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 W, 8E 0

31. Date filed (Month, Day, Year) APR 25 82 Registrar's Signature



			For State Registrar	State of Ma	aryland		artment of F		-	giene Reg. No.	2008	13568
		ч	Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath	Vaar	3. Time of Death
	Physicia /Medic		David Bruce Ber	nef i eld					April	9, Day	2008 Year	6:55 P M
	Examin		4a. Facility Name (If not institution, g				-	r Location of Deal	th		County of Death	
		Ч	Renaissance Garde				Silver S		8. Date of Bir		ince Geo	
Ĺ	Funeral Director		257-20-9681	Sex 7. Ag	e (In yrs. las	Yrs.	Months Days	Hours Min		1928	Cou	place (State or Foreign ntry) g1a
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary fied a	tor	MD Prince (George's	Silve	er Sp	ring					1 □Yes 2 No
	r 28a	irec	10e. Street and Number	20186 2			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	th with	al D	3142 Gracefield H	Road MG 420			20904	_		USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? XXYes 2 If Yes, Give	No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
8	hours tural"	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	-	16a. Dece	dent's Usual Occur	pation			mil_ nd of Business/Ir	
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pu	al Hyg	BeC	17. Father's Name (First, Middle, La.						me (First, Middle		Surname)	
Val	ould b Ment arked atic e	Tol	William Edgar Ber						Buernie			
, Maryland 21215-0036	and 2 shi salth and n 27 is m		19a. Informant's Name/Relationship Julia C. Benefie			3142		ld Road 1	MG 420 S	ilve	r Spring	, MD 20904
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spec				sition (Name of matory or other pla e Cremato		Date 11/08		sville,	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	Ho Otto	MO12		Name and Addre					ox 784 .e, MD 2102
μ		-	23a. Part1. Enter the decase, or co shock, or heart failure. List on	mplications that caused		Do not en	er the mode of dyi	ng, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between
0	Physician		Immediate Cause (Final disease or condition	_a. Cerebroy								Onset and Death 6 months
1	/Medical		resulting in death)	Due to (or as			0240110					
	Examiner	_	Sequentially list conditions,	b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):								
	bed lsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ince oi).						
-6	ate be executed only sician and the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
8760	e be e	dical		d								
9		ledi										
P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	leath 3[□Ectopic pregnanc □ Other <i>(specify)</i> _	у		2	23d. Date of deliv Month	very Day Year
	requires that the een signed by th rould be detache		Part II. Other significant conditions	_		ing in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
rds	quires an sign	q p	Atrial Fibrillat	ion, Dyspha	agia				1 🗆	Yes 2[□ No 3□ Pro	bably 4 Nhknown
Division or Vital Records,	has has	Completed by								opsy ormed?	death?	topsy findings available ompletion of cause of
tal	ician: Th certificate ector, pag		25. Was case referred to medical					26. Place of De	1 Yes eath (Check only	2 XNo	1 Yes	2 □ No
>	Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpati	ent 2∐El	R/Outpatie	nt 3 DOA Oth		Home 5 ☐ Res		6 □Other (Spec	ify)
0	ding Phys n. After this funeral dii		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju		28b. Time o	f 28c. Inju Wo		28d. Describe			
<u>i</u>	ttending death. stor: After the funer	atio	2 ☐ Accident investigat	ion				Yes 2□No				
Divis	tal or Att s after de al Direct ed in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of in building, e	jury - At hom tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28f. Location City or To	(Street an wn, State	nd Number or Ru	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical (Physician: To the best amirer. On the basis of and manner st	of examination							
)	To ti withi. To ti comp	Me	29b. Signature and title of contrier	Se.			29c. Licens D2403				te signed <i>(Month</i>	
1	130		30. Name and address of person wh	no completed cause of	death (Item 2	23a) (Type,	Print)					
رط	/W .		Eugene Machado,	M.D. 3110	Gracef	ield	Rd. Silv	er Sprin	g, MD 20	904		
	Sta Regist		31. Date filed (Month. Day, Year)	2008 32. Projist	rar's Signatu	ıre						
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 💪 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8, 11:40 PM ELIZABETH HENRY BELLMER April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Vincent's Care Center Emmitsburg Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 30, 1927 9. Birthplace (State or Foreign **Funeral** Months Days Hours 80 579-66-9297 Director New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Funeral Director Frederick 1X Yes 2 No Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 South Seton Ave. 21727 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 📉 No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) Teacher Notre Dame De Namur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Bellmer Elizabeth Jakob ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 South Seton Ave./ Emmitsburg, MD Sister Camilla Harant 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sister of Notre Dame |04/11/2008 | Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licen 104 E. Main St./ Thurmont, Maryland 21788 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Nots disease or condition resulting in death) /Medical Due to (or as con equence of **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician d be detached for use as the huria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours at To the Funeral D Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1). 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IBR 10 ur ou. 31. Date filed (Month, Day, 32. Registr State 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Hattie Reth Carroll 3:35 P M April 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Julia Manor Nursing Home Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours 98 Yrs. Maryland 219-12-1290 Jan.7,1910 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 South Pointe Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Packing Clerk Refrigeration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clinton Hubert Jamison Rosa Florence Clipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Evelyn L. Eichelberger - Daughter 1210 South Pointe Dr. Hagerstown.MD 21740</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donatier 5 Other (Specify) Mt.View Cemetery 04-15-2008 Sharpsburg, Maryland 21. Signature of Funeral Sewisa 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cerebro vascular Due to (or as a consequence of): emention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? bably 4 Sunknown opsy findings available empletion of cause of

Physician /Medical Examiner

Physician

/Medical

Examiner

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Be Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If Itam 27 is marked other than "natural; or Itams 23s or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or itams 23s or 28a-f show traumatic event, the Medical Examiner must be maitled at

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permit. Page Department of Important: if any injury or once.

Examiner ed by the attending physiclan and detached for use as the burial-tran Physician/Medical been signed by to should be detach þ Be Completed funeral director, Certification: To filled in by

25.

29a. Certifier

(Check only one

Hospital or Attanding Physician: The law requires that the death certiticate be executed

this

Atter

hours after death

Coithin 24 hours

To the

Medical

State

Division of Vital Records, P.O. Box 68760

IF FE	EMALE:	
23b.	Was deced	ient pregnar
		12 months?
	1 Tyes	2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 Yes	2 _]No	3 ☐ Pro	bably	
24a.	Was an autopsy performed	17	24b.	Were autoprior to co	opsy fin	d
10	Yes 2	No		1 Yes	2 🗆 N	c

							4	
Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 PNo	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3□ DOA	Other:	4 S Nursing Ho	me 5 Residence	6 ☐Other (Specify)	
Manner of Death	28a. Date of Injury			Injury at		28d. Describe how in		

27. Manner of Death 1 ➡Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	t, fact	ory, office

. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗌 No	28d. Describe how injury occurred
farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physi 2 Medicel Examine	ocien: To the best of my knowledge, death occurred at the time, date and place er: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29b. Signature an	d title of certifier	
N .		

052323

29c. License number

29d. Date signed (Month, Day, Year) 04-14-2008

arles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Khalid M. Waseem M.D

31. Date filed (Month Day, Year, APR 14 2008



Hagerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year H 2:30 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16505 Virginia Ave., C-31 Washington Williamsport 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 K F 220-16-3727 96 11/02/1911 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Washington Williamsport 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave., C-31 21.795 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Frank Corbett Catharine Ardella Greenwalt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Crabtree 12319 Dellwood Avenue, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 04/17/2008 Pauls Cemeterv Clear Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) oronary Antery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 TONo 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examiner

physician

attending

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certificate |

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After

Director:

To the Funeral Direct completely filled in by

Medical

or Attending Physician:

To the Hospital within 24 hours a

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that the death certificate be execute

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notifled at

23a or

r than "natural", or Items the Medical Examiner mu

injury or other traumatic event,

within 72 hours after

d 2 should be filed w th and Mental Hygier 7 is marked other th

permit. Pages 1 and 2...
Department of Health at Important: If Item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

MD

Director

Funeral

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Completed

Be

Examiner Physician/Medical þ Completed ٩ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 mon 9 Unknown

25. Was case referred to medical examiner?

2 No

1 🗌 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

performe

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one) 6 ☐Other (Specify)

Other: 4 Nursing Home 5 Residence 28d. Describe how injury occurred

28c, Injury at Work? 1 Tyes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3□ DOA

2 ER/Outpatient

28b. Time of

Injury

1 🗹 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number

State

Hagerstown,

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2008 1:21PM M ROBERT C. CANAVELLO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT 8522 NORTH BEND ROAD EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 **X**M 2 □ F 82 Director MAR 29,1926 **NEW YORK** 051-20-7234 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits EASTON 1 ☐ Yes 2 No Director MD TALBOT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 21601 USA 8522 NORTH BEND ROAD Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 YACHT BROKER MANUFACTURING of Health and Mental Hyg If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY ELIZABETH CURRAN CHARLES CANAVELLO 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8522 NORTH BEND ROAD, EASTON, MARYLAND 21601 MARCIA CANAVELLO/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If Itel any Injury or other 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State THE EVERGREENS CEMETERY 4/3/2008 BROOKLYN, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 soseph Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) rebrocascular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown ate has been signed page 2 should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No ို 3 DOA 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EW PISCHER 2 Martin egistrar's Signature 31. Date filed (Month State Year) 0 4 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20, 2008 12:02A M HOWARD EARL CONNERS April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4/2/1920 Bel Air Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 218-09-3368 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Harford Jarrettsville MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3624 Anderson Lane 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien important: If Item 27 is marked other tha any Injury or other traumatic and other than 100ce. 8 Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Earl Conners Sr. Catherine E. McElrov ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) Mary Beth O'Donnell (Dau.) 3624 Anderson Lane Jarrettsville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/23/08 St. 4 Donation 5 Other (Specify) Joseph Cem. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause it e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disease Coronary **Physician** y ELLES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Infarction Myocardial 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division or Vital al or Attending Patter death.

Saltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kerin

BURGER 32. Registrar's Signature

and manner stated.

ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNCH

ORIGINAL

D35012

21014.

Md.

29d. Date signed (Month, Day, Year)

04/20/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 1:32 A M 11 David K. Crawford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 2542 North Farm Rd Ellicott City Date of Birth (Month, Day, Year) Sept 7,1950 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 F Arkansas 450 84 6802 57 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County a or 28a-f show t be notified at 10a, State 1 ☐ Yes 2X No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r Items 23a o iner must be 21042 United States 2542 North Farm Rd by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced er than "natur , the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event. Mortgage Co. Mortgage Broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keith Arvil Crawford Vera Dean Morrison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9414 Chippenham Drive Laurel Alicia M. Gregory/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ♣ Other (Specify entombment 4-14-2008 | Clarksville, MD Columbia Mem. Park 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Dicensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASMATE **Physician** disease or condition resulting in death) MINCHEATIC /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗆 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician this After 24 hours after death Funeral Director: within 2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

"natural", or

Baltimore, Maryland 21215-0036

NAIMISH 31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier

Medical

HYSICIAN

29d. Date signed (Month, Day, Year)

UD

April 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. GREENE ST UNIV. 32. Registrar's Signature

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

APR 14 2008

~>>



08-026	67
James	Clark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 1357 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle,Last) Physician/ Month 0355 hrs April 5, 2008 Medical Examiner Carroll clames c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Wicomico Salisbury Peninsula Regional Hospital Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min Months Davs Hours 5 Country) -11-1947 Director 6 Yrs 1 🔀 M - 54-9849 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County iny 10a State 1 Yes 2 No Withams 'natural", or items 23a or 28a-f show Examiner must be notified at once. Hccomach Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 23488 Parker Rogo Neal 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 2 Married Never Married Yes White Specify: Yes 2 No specify. 3 Widowed Divorced If Yes, Give Year ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) the Medical Baltimore, MD 21215-0036 onstruction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) lark auna or other traumatic event, Be Malter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ithams UA 23488 Neal Parker Clark 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Exmore, VA 4/11/08 Occohannock Crematory Donation 5 Other Specify Chinecteogue, UM 23336 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Church St C- Botto Funeral Home manda 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. Death /Medical a. Contact Gunshot Wound of Torso Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED e attending physician for use as the burial -UNPENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Dav Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown 23e. Oid tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed certificate has 2 No 1 🗸 Yes Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Other₄ Hospital: 1 Other examiner? Nursing Home 5 Residence 6 DOA 2 V ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death Subject shot self Certification: FOUND: 1 Yes 2 ✔ No Natural Pending Apr 5, 2008 0247 hrs Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide or Town, State) 6187 Neal Parker Road, New Church, Va. Could not be determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 6, 2008 O.C.M.E. MIP 30. Name and address of person who completed cause of death (Item 23a)

Registra

31. Date filed (Month, Day, Year)

Tasha Greenberg MD.

Assistant Medical Examiner Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** John Alan Depew 10:20 PM April 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 3 Silverwood Circle, Apt. 3 Annapolis 8. Date of Birth (Month, Day, Year) April 9, 1961 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days **100** MM 2 ☐ F Maryland 216-68-8681 46 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Annapolis Anne Arundel Maryland 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 U.S.A. 3 Silverwood Circle, Apt. 3 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Mo If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 3 Married 1 ☐ Yes 20 No Specify: Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel Stock Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Jean Howard Robert Wayne Depew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Silverwood Circle, Apt. 3 Annapolis, MD 21403 Shawn Depew/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 4/11/2008 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 0 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DRONAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) be detached the 9∏Unknown 9 Hinknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DEDUNDANT 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autop performed 2 XI has MAIZUR TRUNG I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death pletely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di curlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Heritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8005-90-40

Registrar

DHMH 17 Rev 1/2001

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Huy Stetoo Annapmi 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 1 0 2008

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		For		State of M	larylan		artment of H		Mental Hy	giene		
		1 - State Registrar				Cei	rtificate of	Death	T	Reg. No.	118	13577
Physici		1. Decedent's Name Lorene		ast) Doolin					2. Date of De Month	31 Day 20	0 Xear	3. Time of Death 4:15p M
/Medic Examin		4a. Facility Name (I	f not institution, g	ive street and number)		4b. City, Town, or	r Location of Death			ty of Deat	
ПШТ		William					Easto			Talb	ot	
Funeral Director		5. Social Security N 447-03-6		Sex 7. A		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 1, <i>Year)</i> 1,915	Co	hplace (State or Foreign untry)
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arylan show d at	-	10a. State Md	10b. County Talbot		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits 1X Yes 2 □ No
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ems 2	Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an. Mexican. Puerto	pecify Yes or No Rican, etc.))- 14. R	ace - Amer	rican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Marri 3 ☑ Widowed	ried 2 ☐ Married 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates:	No	I	1□Yes 2ၨZNo	Specify:		Spec	TA.	hite
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shou and M s mar		19a. Informant's Na		, ,,		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Z	ip Code)
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Depa Impo any ir		Tures	L. Ante	Il thele	2 .	R	Name and Address Carro O. Box	ll Húrle 518. St	y Fund Micl	eral H haels.	ome,	PC 21663
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Physician		Immediate Cause (disease or condition resulting in death)	(Final n	_a. /2_	SUIY	An	my fo	il we)		K	Spiset and Death
/Medical Examiner		resulting in death)		Due to (or as	s a conseq	uence of):	1.1	,				1
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and L-transit	Examine	it any, leading to himbolistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
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i lcian; Th certificate ector, pag	Be	25. Was case reference examiner?		Hospital:			Oth	26. Place of Deal	th (Check only o	one)		
Phys r this ral dir	- To	1 ☐ Yes 2 ☐ 27. Manner of Death		28a. Date of Inj	ury	ER/Outpatien 28b. Time of		Nursing H	ome 5 ☐ Resi	dence 6 0		eify)
nding ith. r; Afte e fune	ation	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	(Month, D	ay Year)	Injury	Worl	k? Yes 2 □ No	200. 00001150	non injury occi	arroa	
r Atte ter des irecto ir by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d Zoe. Place of in	jury - At ho	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Ru	ral Route Number,
pltal o		29a. Certifier	1 Cortifuing I	Physicians To the best	of my kno	vulodao dosti	a accounted at the stime					
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to	Medical	(Check only one)	2 Medical Ex	Physician: To the best aminer: On the basis and manners	of examina	ition and/or in	vestigation, in my o	pinion, death occu	red at the time	date and place	nanner as e, and due	to the cause(s)
Vithir Comp	Me	29b. Signature and	title of certifier	TR N	17		29c. License			29d. Date sign	ed (Month	n, Day, Year)
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			ress of person who	o completed cause of			,	F - 1		04.55		
Sta	te	31. Date filed (Mon		32 Regist	rar's Signa	ture	ld Ave.	, Easto	n, Md.	21601		
Registr	ar	A	rk U 3 2	UUB Ester	w L	ature	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4c. County of Death Zina Towanna Dorsey-Toye 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner ϵ ente Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) **Funeral** Months Days Hours Min. 1 M XXF 215-62-8333 Director 54 Feb.12.1954 Maryland Usual Residence of Decedent Pages 1 and 2 should I'e filed within 72 hours after death with the Maryland nent of Health and Men al Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f sh 1 ☐ Yes 2x No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 3605 Moses Way ral" or items 23a Examiner must b Apt. 119 20602 U. S. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Secretary Dept. of Defense is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas P. Jupiter ပ Ruby L. Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Cleo Comer / Sister 3605 Moses Way Apt.329 Waldorf, MD 20602 ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or oti APRIL Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shiloh Ch.Cemetery 25, 2008 Newburg, MD 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service License M00641 5635 Washington Ave., La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner moplysi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner 2 nce Hospital or Attending Physician: The law requires that the death certificate be executed Mnoxic and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 4□Pregnant at time of death the 9 Unknown 9 \ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑1 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Horne 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 1 Inpatient P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🕡 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: filled in by

> State Registrar

Medical

(Check only one)

Virmula 31. Date filed (Month, Day,

29b. Signature and title of certifier / 1

DHMH 17 Rev 1/2001

and manner stated

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

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Year)

APR 2 5 2008

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D4573

3328 Old Washington Rd.

29d. Date signed (Month, Day, Year)

4119108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 18^{ay} 2008 1240 а м **Physician** Annalea Virginia Dawson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Williamsport Homewood of Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 6-26-1921 Months Hours Martinsburg, WV 1 ☐ M 2 🖫 F 86 235-56-3344 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 🏖 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any hijury or other traumatic event, the Medical Examinar must be notified a once. Director Williamsport MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 U. S. A. 16505 Virginia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 □ Divorced No Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dawson's Hardware College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leatha Beeler Pyne Roland Merville Pyne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 189 Winslow Dr., Martinsburg, WV 25401 Lance Stotler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Chapel Cemetery 4-21-08 Berkeley Springs, WV 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHunter-Anderson Funeral Home of Fund Service Ligar 36 S. Green Street, Berkeley Springs, WV 25411 221 2. Part1. Enter the disease, or complications tile, caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause | | each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) MUNITA **Physician** /Medical to (or as a consequen EMENTA WITH AGGNESSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 -TISAILLATION 1□ Yes the Hospital or Attending Physician: nin 24 hours after death. After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Property after after the full the 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, doubt occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature ar 0 30 Name and address of p

State Registrar 31. Date filed (Month, Day,

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32! Registrar's Signature

METERIEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 19 08 2303 04 **EVANS** DOROTHY VIRGINIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS BRADDOCK CAMPUS Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🔀 F Yrs MARYLAND 7-14-1917 90 Director 215-20-6366 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County Show notified at 1 ☐ Yes 2 No RAWLINGS ALLEGANY Director MD 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or the Medical Examiner must be UNITED STATES 21.557 16001 MOUNTAIN RIDGE ROAD death v Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 □ Never Married 2 □ Married 0. 1 ☐ Yes 2 🕱 No WHITE Specify: Specify: Baltimore, Maryland 21215-0036 þ 3 □ Widowed 4 N Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than BEAUTY SALON COSMETOLOGIST 10 ith and Mental Hygie 27 Is marked other r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental JULIA MARY LYONS BROWN ROBERT BROWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health airem 27 ls 16001 MOUNTAIN RIDGE ROAD RAWLINGS MD 21557 JOSEPH RICHARDS SON other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or 4-21-2008 CUMBERLAND, MD CUMBERLAND CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. FROSTBURG. Approximate Interval Between Onset and Death Immediate Cause (Final 40015 reventicolor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy has performed 2 2No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 🕅 2 ER/Outpatient 3 DOA 1 hpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? 27. Manner of Death After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD MP11

Mysician



Scto-

within 24

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02945 State of Maryland / Department of Health and Mental Hygiene Jonathan Claude Fowler Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day April 15, 2008 Physician/ 0816 hrs Jonathan Claude Fowler ¬I Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Edgewater 4079 Cadle Creek Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1/17/1953 Director 214-62-0729 55 XXM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 1 Yes 2XX No Lothian Anne Arundel MD 23a or 28a-f sho notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 20711 5442 Solomons Island Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XXNever Married 2 Married Yes 2 XX No White Specify 1 Yes 2 X No specify: Pages I and 2 should be filled within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", o Yes, Give Year 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Marine Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miriam Lenhert James Elmer Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD 21061 102 Ferndale Rd. Judy Bragg 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State West River, MD 4/21/2008 Our Lady of Sorrows permit. Pages Department o Important: Donation 5 Other Specify: 22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401 nature of Funarah Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death **fledical** Narcotic Intoxication Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physicians. The law requires that the death certificate be executed and /sician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/29/08 amh X UNPENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month Day Year 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth Pregnant at time of death Other (Specify, 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ð 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 DOA ER/Outpatient 3 Inpatient 2 this I dir 1 🗸 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 X No Natural Pending Director: d in by the f Fnd 4/15/08 Unk hours after death Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be or Town, State) 3 Suicide determined Fdgewater MD (Specify) Marina 079 Cadle Creek Rd. within 24 hours a To the Funeral I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific April 16, 2008 O.C.M.E.

Jan 1

Registrar

DHMH 17 Rev 1/2001

OCME 2006

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Laron Locke MD.

31. Date filed (Month, Day, Year APR 1

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan		artment <i>rtificate</i>			d Mer		giene leg. No.2	008		3582
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			BALTIMORE WASHINGS. Social Security Number		. Age (In yrs.	last birthday)	If Under 1		VIE Under 24 F	Irs. 8.	Date of Birth	1	O Riet	oplace /St	ate or Foreign
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36	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or lieme 23a or 28a-f ehow event, the Medical Examinar must be notilised at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? E⊠No	.S. 13.	Was Decede If Yes, speci 1 Yes 2		nic Origin? lexican, Pu pecify:	(Specify uerto Rica	Yes or No- an, etc.)		Race - Ame Black, White becify:		,
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	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition		20b. I	Place of Disponentery, cre	osition (Nam	ne of		Date			tion - City or	Town, Sta	te
E C	Pages nent of I nnt: If its ury or o		12 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate i	inity N			rd 4	/11/	2008	Wald	orf, M	D	
Baltimore,	permit. Pages Department of Important: If ite eny injury or of		21. Signature of Funeral Service							larde Ann	sty Fi apoli:	unera s, MD	1 Home 21401	, P.A	Α.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the dea	th. Do not en	ter the mode	of dying, s	uch as care	diac or re	spiratory ar	rest,		Approx	rimate I Between
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_	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	c	r as a consec	quence of):									
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Box	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of a	al death 3	⊒Ectopic pre ⊒ Other (spe					230	d. Date of de Month	ivery Day	Year
ds, P.O.	ires that the de signed by the e d be detached t	ρ	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the t	underlying ca	ause given ir	n Part I.			obacco use	contribute to		of death?
ö	w requir been si should	etec								-	24a. Was	20	24h Wara ai	itoney find	lings available
Records,	The lay	Completed							-	-	autop	rmed?	prior to death?	completion	of cause of
<u>a</u>			25. Was case referred to medica					26	Place of	Doath (C	1 ☐ Yes heck only o	2 1No	1 🗌 Yes	2 € No	
Vital	Physician: this certifice ral director, p	To Be	examiner?	Hospital:	patient 2] ER/Outpatie	int 3□ DO	Othor					☐Other (Spe	cifv)	
on of	ding Phy h. After thi funeral c		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	y		28b. Time o Injury		8c. Injury at Work?		-	. Describe h				
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h g, etc. (Speci	nome, farm, st	treet, factory	, office		28f.	Location (S City or Tox		Number or R	ural Route	Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Co		ng Physician: To the l Examiner: On the ba and mann	sis of examin										use(s)
	To the within 2 To the comple	Mec	29b. Signature and fittle of contifie		o. stated.		29c	. License nu	ımber			29d. Date	signed (Mon	h, Day, Ye	ear)
	⊢₃⊢ŏ		1/5	e e.				Dong	(2)	23		Apr	il 6,	200	5
			30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type						11/1	_ 0/		O
T	CH	+	Dr. Tsion Berha					ical (Cente	r 30	l Hosp	oital	Dr. G	B, MI	21061
	Sta	ate	31. Date filed (Month, Day, Year)	32.	gistrar's Sign	ature									
	Regist	rar	APR 1	0 2008	we.	K 4	well								

FISHER, SANDRA

WCHD/SH 4/22/08 per FH Certificate of Death

1. Decedent's Name (First, Middle, Last)

Pamela Elizabeth Funk

Physician

/Medical

3. Time of Death

6:35 p^M

	Examir	Examiner 4a. Facility Name (If not institution, give street and number)						4b. City, Town, or	r Location of Death	4c. County of Death					
		A CONTRACTOR	Western	Marylar	d Hospi	ital (Center		Hagersto	WIT lades 24 Hzs	1	Washington			
	Funeral		5. Social Security !		6. Sex 1 ☐ M 25		je (In yrs. ias	st birthday) _ Yrs.	Months Days	Hours Min.	8. Date of B (Month, D	irth Day, Year) RO 107	9. BI	rthplace (State or Foreign country) w York	
	Director		214-48-8 Usual Residence of				60				Jan.	10,134	IN INC	W TOLK	
	yland		10a. State	10b. County			10c. City,	Town or Loc	ation					10d. Inside City Limits	
	a-1 s	cto	wv	Jeffe	rson		Har	pers I	Ferry					1 Yes 2 No	
	th the	- lre	10e, Street and Nu	ımber					10f. Zip Code				en of What C		
	238 Last b	le l	1198 Joh	nnycake	Lane				25425				U.S.A.		
	er de	Funeral Director	11. Marital Status		Arm	ed Forces?		. 13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	10-	 Race - Am Black, Wh 	erican Indian, ite, etc.	
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene of other than "natural", or flems 23a or 28a-1 show event, tra Medical Examinat must be notified at	þ	1 Never Mar	,	ned 1 1 1 Yea	Yes 217 es, Give ir or Dates:	No	1	☐Yes 2M_No	Specify:			Specify: W	hite	
5-(natu	Completed	(Spe	15. Deceden cify only highe	t's Education st grade compl	leted)		(Give k	ent's Usual Occup tind of work done of ONOT use retired	during most of worl	king	16b. Kin	d of Busines:	s/Industry	
12	withir ene. then	E D	Elementary/Sec	ondary (0-12)	Coll	ege (1-4or				1)		Tro	nsport	ation	
	filed Hygi ther int, I		17. Father's Name	(First, Middle,	Last)			<u>Manage</u>		18. Mother's Nam	ne (First, Middl			trude Allen	
Maryland	Mental Mental arked o	To Be	William-	F. Dat	Will	iam E	ngel I	Patter	son	-Lillian	a Allen	Lilli. ►	an Ger	trude Allen	
2	2 should be and Menta se marked sumatic ev	-	19a. Informant's N			nt)		19b. Mailing	Address (Street	and Number or Ru	ral Route Num	ber, City or	Town, State,	Zip Code)	
	C1 C0 - 60		Michael	Hollob	er/Son			1198	Iohnnyeal	re In. Ha	rnare l	Forev	West 1	/irginia 254	
re,	s 1 a of Hei Item		20a. Method of Dis	•			000	ce of Dispos	ation (Name of atory or other place		Date	20c. Loc	ation - City o	r Town, State	
E	Page nent o int: If iry or		1 ☐ Burial 2 4 ☐ Donation	Cremation 5 ☐ Other (S	3 ∐Removal pecify)	from State		-		ory 4/16/	2008	Smi	thsbur	g, MD	
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any Injury or other tr		21. Signatur f F	uneral Service	Lighton					ss of Facility Res		n Fun	eral C	hapel	
Ω_	\$ Q E E 8		En	5	1			16	01 Penns	ylvania A	Ave., H	agers	town,	MD 21742	
15			23a. Part1. Enter shock, or he	the disease, or art failure. List	complications only one cause	that caused e on each li	d the death.	Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between	
1	Physician		Immediate Cause disease or conditi	on	2		SE	PSI.	5					Onset and Death 2 WEEKS	
E 40	/Medical Examiner		resulting in death)	Due to (or as a consequence of):											
	CAMILITIES	_	Sequentially list co	onditions,	b			NG	MISSC	E 55				2 MONTHS	
	sit ed	Examiner	Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events b. LUNG ABSCESS Due to (or as a consequence of). CANCER										UNKNOWN		
	and and	xan	that initiated event	at infilated events c. Due to (or as a consequence of):									UNKNOWN		
09	be e sicien buria						·	•							
68760,	ficate g phy: is the	edic			G										
Вох	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceded	nt pregnant			of pregnance		F-4			2	3d. Date of de	elivery	
	death e atte	Ca	in the past 12 1 Tes 2	2 months?	4	Pregnant a	2 ☐ Fetal d t time of dea		Ectopic pregnancy Other (specify)				Month	Day Year	
P.0	that the de ed by the detached	hys	9 🗆 Unknow	n	9⊔	Unknown							_		
	es tha	by F	Part II. Other sign	ificant condition										to the cause of death?	
ord	The law requires that has been signed page 2 should be considered.	ted			Miu	1171	PLE	500	LEROS	15	1	Yes 2]No 3∏F	Probably 4 Unknown	
ec	a	ple									24a. Wa	s an opsy	24b. Were a	autopsy findings available completion of cause of	
- H		Completed									per 1 ☐ Yes	formed? 2 XNo	death?	s 2 No	
of Vital Records	Physiclan: Th r this certificate ral director, pag	Be	25. Was case refe examiner?	rred to medica	-				Lau	26. Place of Dea	th (Check only	one)			
of C	physic this c	၉	1 Yes 2		Hospital:	1 🔲 Inpatie		R/Outpatient		4V Nursing H				ecify)	
'n	ing F	0	27. Manner of Dea 1 Natural	5 🗌 Pendir	9	Date of Inju (Month, Da	ly Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe	e how injury	occurred		
isic	death death stor:	cat	2 Accident 3 Suicide	investi 6 □ Could	not be	Place of In	iuny - At hom	a farm stra	M 1 [Yes 2□No	28f Location	/Street and	Number or F	Rural Route Number,	
Division	or A after Direction by	Certification:	4 🗌 Homicide	determ	nined 200.	building, et	ic. (Specify)	ie, iaim, site	et, factory, office		City or T	own, State)	rivalinger or r	iurar rioute ivumber,	
_	spitel ours nerel filled		29a. Certifier	1 Certifyin	ng Physician:	To the best	of my know	ledge, death	occurred at the tir	ne, date and place	and due to th	e cause(s) a	and manner a	as stated.	
	e Hos 24 h e Fur	Medical	(Check only one)	2 Medical	Examiner: On	the basis of manner st	of examination	on and/or inv	estigation, in my o	pinion, death occu	rred at the time	e, date and	place, and du	ie to the cause(s)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and	d title of certifie	r				29c. Licens	e number		29d. Date	signed (Mor	nth, Day, Year)	
				4	my L		•		D 40	1996		A/2	41/12	nth, Day, Year) -, 2-008	
N 5.	H-5		30. Name and add		who completed	d cause of o		23а) (Туре, F	150	O Pennsyl			e		
الريا	and the same of	ate					rar's Signatu	ıre	Hag	erstown,	MD 217	42			
	Regist		31. Date filed (Mo.	APR 15	2008	A		N A							

itizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry ansportation n Sumame) ian Gertrude All**e**n or Town, State, Zip Code) West Virginia 25425 ithsburg, MD neral Chapel stown, MD 21742 Approximate Interval Between Onset and Death 2 WEEKS 2 MONTHS UNKNOWN 23d. Date of delivery Month Year Day use contribute to the cause of death? □ No 3 □ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) iry occurred nd Number or Rural Route Number, s) and manner as stated.

nd place, and due to the cause(s) tate signed (Month, Day, Year) 110

2. Date of Death Month

Day

April 12, 2008

		-	For State Registrar	State of M	arylan		artment of H <i>rtificate of I</i>				giene Reg. No. 🥎 🏌	100	10001
	Physicia	 20	Decedent's Name (First, Middle, La	(st)		*				2. Date of De		Year	3. Time of Death
	/Medic	al	4a. Facility Name (f not institution, give	n atmost and number		+	4b. City, Town, or	Location		Aprill	- 11	2008 y of Death	1945 M
	Examin	er	M 1: 11	iking this	oita	l	Rultin		atr		Ba	11	ore
	Funeral Director		5. Social Security Number 6. 220–54–2705		e (In yrs. I	ast birthday) O Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da Feb 2,	th ay, Year)	-	lace (State or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	e Mary a-f sho ified a	ctor	MD Fred	erick		Casc	ade						1 □ Yes 2X No
	vith the	Director	10e. Street and Number				10f. Zip Code	.719			10g. Citizen of	What Cour	ntry?
	ns 23e must	Funeral	5034 Wise Ro	12. Was Decedent	Ever in U.	S. 13. \	Was Decedent of H		igin? (Spe	cify Yes or No		ce - Americ	
036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No No		lf Yes, specify Cuba 1 ☐ Yes 2🎇 No	an, Mexicai Specify:		Rican, etc.)		ack, White, fy: wh.:	
2	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual Occup kind of work done of DO NOT use retired	ation during mos	st of workin	g	16b. Kind of E	Business/In	dustry
21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		lomemaker	1)			Ov	n hor	ne
	al Hygie I other vent, th	Be C	17. Father's Name (First, Middle, Las	")				18. Mothe	er's Name	(First, Middle	, Maiden Surna	me)	
Maryland		오	Harvey D. Cali			40: 11:31				Daws			
Mai	tra tra		19a. Informant's Name/Relationship Richard L. Feut		d		ng Address (Street Wise Rd					n, State, Zip	Code)
ore,	es 1 and 2 of Health item 27 i	111	20a. Method of Disposition		20b. P	1	sition (Name of matory or other place			ate	20c. Location	- City or To	own, State
Baltimore,	Page Iment tant: It		1 ⊠ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	fy)		st Have	en Mem Ga	rd. C				mont,	
Bal	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	Berulers	W	- 1	2. Name and Addre						Home, Inc.
19			23a. P Enter the disease, or constitute, or heart failure. List only	nplications that cause one cause on each l	he death ine.	n. Do not ent	er the mode of dyir	_			arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	Consequ	Or yar	1 Syste	m	fin	hre			48 hours.
	Examiner		Sequentially list conditions,	, Fum	2000	9							iodays
	ed isit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	Consequ	uence of):	1-0.	drsea	.0				110/10
Ć,	execui in and ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):	rum a	Misca					year 3
68760,	icate be executed physician and s the burial-transit	edical		d									
_	death certific attending pl		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. D	ate of deliv	ery
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			□Ectopic pregnanc: □Other (specify)	у			- 1	onth	Day Year
	ss that gned b	by Pi	Part II. Other significant conditions	contributing to death I	out not resu	ulting in the u	nderlying cause giv	en in Part I	l.	23e. Did	tobacco use co	ntribute to t	he cause of death?
ord	w requir been si should t	ted								1 🗆	Yes 2 No	3 ☐ Pro	bably 4 Unknown
Rec	has b	Completed								24a. Was auto perf	psv	. Were auto prior to co death?	opsy findings available empletion of cause of
Vital Records,	yslcian: The iis certificate hadirector, page	Be Co	25. Was case referred to medical					26. Place	e of Death	1□ Yes (Check only	ormed? 22 No one)	1 ☐ Yes	2 □ No
Z <	hysici his ce il direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpaties		4 L N	ursing Hor	ne 5∐Res	idence 6 □0	ther (Speci	fy)
uc	dlng P. After i funera	ion:	27. Manner of Death 1 Natural 5 Pending 2 Decident investigation	28a. Date of Inj (Month, Da		28b. Time o Injury	Wor	ryat rk? ∣Yes 2⊟		28d. Describe	how injury occu	ırred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	ertification:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	28e. Place of in	jury - At ho tc. <i>(Specif</i>	ome, farm, str	reet, factory, office	700 [(Street and Nun own, State)	nber or Rur	al Route Number,
	Hospital 24 hours Funeral etely filled	edical Co	29a. Certifier 12 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred at the ti	me, date a opinion, de	and place, a	and due to the	e cause(s) and r	manner as : e, and due	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier				29c. Licens				29d. Date sign		Day, Year)
			> Katti vos Mu	m mo			Res	-00	06		April Manyla	11,	2008
11	4-10		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type, Wol	fe Street	+	RUL	Mine	1	 - لی	21287
	Sta	ato	31. Date filed (Month, Day, Year)	9 1	rar's Signa		10 3114		134111	, in the	101014 16	unci	61601

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02574 State of Maryland / Department of Health and Mental Hygiene Melissa Gorelik 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0906 hrs April 1, 2008 Medical Examiner Melissa B. Gorelik 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 10124 Owen Brown Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Country)Maryland **Funeral** Days Hours Director 2X F 213-06-0820 28 Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once Columbia Howard Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 10124 Owen Brown Road 21044 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 2 X No Yes Specify: White Yes 2 X No specify: If Yes. Give Year Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Radiologist Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be Marsha Harris Ivan Gorelik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ivan Z. Gorelik - Father .0124 Owen Brown Road Columbia, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Saltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: | injury or oth Columbi<u>a Mem. Park</u> 4/3/2008 Columbia, Marvland Donation 5 Other Specify: 21. Signature of Funeral Service Licen 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville MD 20852

Part I. Enter the disease, of complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sonold. Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death / /Medical a. Alprazolam, citalopram and hydrocodone intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. by Part II. Dther significant conditions o þ Yes 2 ✔ No 3 Probably 4 Unknown σ. Completed Records, this certificate has been s il director, page 2 should l 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Vital Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? 28b. Time of Injury ŏ After 27. Manner of Death subject ingested medications 5 FOUND Division Natural Yes 2 V No Pending Director: d in by the f 24 hours after death 0900 hrs Apr 1, 2008 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 🗸 Suicide Could not be or Town, State) 10124 Owen Brown Road, Columbia, MD determined (Specify) Single Family Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 1, 2008 O.C.M.E. TUD) Laste

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2008

OCME

Tasha Greenberg MD

31. Date filed (Marty Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 8, Day 2008 Year 535 AM M Estelle Goozner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Hebrew Home of Greater Washington Rockville Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign NY Country) 5. Social Security Number 091-16-5976 Days 1072571921 Months Hours 86 1 ☐ M 2 💢 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Fairfax Alexandria 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22309 United States 3614 Becherer Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Deborah Amster Max Goldberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 Becherer Road Alexandria VA 22309 Alan Goozner - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 4/10/2008 Falls Church, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) well a consequence of); Due to (or Due to for as a consequence

Physician /Medical Examiner

Physician

/Medical

Examiner

VA

Director

Funeral

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Completed

Be

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural", or

is marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

and attending physician certificate has After this

The law requires that the death certificate be executed

Records,

Division or Vital Hospital or Attending Physician;

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be Certification: To

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

Due to (or as a consequence of):

5 Other (specify)

3 □Ectopic pregnancy

23d. Date of delivery Month Day

Year

23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown

				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
. Was case referred to medical			26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient 3 DO	Other: 4 Uprsing Hom	ne 5 Residence 6	G ☐Other (Specify)
44 (5 4)	00- D-4(1-1	001 T: (

27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Natura! 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner stated. 29b. Signature and title of certifier

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print) 11.0

31. Date filed (Month, Day, Year) State Registrar

4 Homicide

Pontisse Md Aukuille, Ud 20852

within 24 hours after death To the Funeral Director:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		rtificate of l			Reg. No. 2	08	13587	1
	Physicia		Decedent's Name (First, Middle, Last Dorcas	Harriett	G	igous		Month April	Day	Year 008	3. Time of Death 10:00 P M	
	/Medic Examin	11.538	4a. Facility Name (If not institution, give				r Location of Death		4c. County		10.00 1	
			14231 Shelby Circ			Hagersto				ningt		
	Funeral Director		21/-10-2/34	□M 25FF	95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	th y, Year) 2,1912	Cour	place (State or Foreign ntry) usylvania	
	aryland show d at	,	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2★ No	_
	he Ma 28a-f	ecto	Maryland Washi	ngton	Hagerst	OWN 10f. Zip Code			10g. Citizen of V	Mhat Coul		_
	with t	Funeral Director	10e. Street and Number 14231 Shelby Circl	۱۵		2174	.0		US		iuy:	
	ms 23	nera	11. Marital Status	12. Was Decedent Ever in U	U.S. 13. 1	Was Decedent of H If Yes, specify Cuba		pecify Yes or No		e - Americ	can Indian,	_
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Mamed 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	1 ☐ Yes 21 No		nican, etc.)		ck, White, /: Whi		
Maryland 21215-0036	hin 72 ho e. In "natur Medical I	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	oation during most of worl d)	king	16b. Kind of Bu	isiness/In	dustry	
212	filed witl Hygiene ther tha	Com	8		Hom	nemaker			Domes			
ind	be filed value Hygie of other is event, the	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam	,		ie)		
Z Z	should t ind Ment marked	ဍ	Elmer Stonesife 19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street		Hoffma		State. Ziu	Code)	_
	nd 2 sho lith and 27 Is ma r trauma		Dianna L. Blair/			Shelby (-	217		
Baltimore,	Pages 1 and 2 ment of Health a ant: If Item 27 la ury or other tra		20a. Method of Disposition	20b.		osition (Name of matory or other place		Date	20c. Location -	City or To	own, State	_
<u>iii</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemovai from State	eaver C	reek Ceme	etery 4/1				Maryland	
Salt	permit. Page Department Important: If any Injury o		21. Stantal of Funeral Service Licer	isee		2. Name and Addre					_	
	= @ OI		222 Part States the disease or com	inlications that caused the de-						own,	Md. 21742	
	Di di		23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					11634	4	Approximate Interval Between Onset and Death	
	Physician / /Medical		disease or condition resulting in death)	a. Due to (or as a conse		ndiel	Infan	aun			mnediett	-
6	Examiner		Conventially list conditions	, Ling	Can	cer				11	weeks_	
	po ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a ponse	equence of):							
_	xecute and i-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as a conse	equence of):							_
68760,	ificate be executed g physician and as the burial-transit			ď	,							
	= m #	ledical										_
Вох	w requires that the death cert been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregnancy	y			te of deliv	ery Day Year	
	requires that the death cer een signed by the attendin rould be detached for use	/sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time of 9□Unknown	f death 5[Other (specify)			IVIC	1101	Day real	
P.O.	that the ed by detac		Part II. Other significant conditions	contributing to death but not re	esulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobacco use conf	tribute to t	he cause of death?	
Records,	quires n sign ald be	d by						1 🗆	Yes 2	3 Pro	bably 4 □Unknown	
000	ia so or	Completed						24a. Was		Were auto	opsy findings available ompletion of cause of	_
~	The ate h page	Com		-				auto perfo 1∐ Yes	ormed?	death?	2□ No	
or Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:		Louis	26. Place of Dea					
or	Phys rthis ral dii	<u>유</u>	1 ☐ Yes 2 ☐ No 27. Manper of Death	1 ☐ Inpatient 2 [ER/Outpatie		4 🗆 Nursing n		idence 6 Oth		fy)	_
on	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2∐No	Edd. Boodingo	now injury occur			
Division	l or Atter after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, st cify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Run	al Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) Certifying Pl	hysician: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, deat	th occurred at the tinvestigation, in my o	ime, date and place opinion, death occu	e, and due to the urred at the time	cause(s) and ma , date and place,	anner as s	stated. to the cause(s)	_
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)	_
) All			MDO	05213L	0	41	101	2008	
Á	11 7		30. Name and addless of person who	111 1165	em 23a) (Type,	Print)	1 1 1		1 .^		21205	
1	H-2		21 Date filed (Month Poer, Year)	22 Detecto Cia	Ken	dle K	9 Mi	llans	sport n	NO	2145	
	Sta Registi		31. Date filed (MorAPR Yar)4	2008 32. Hagistrar's Sig	AL A	Carl p						

		1 - State Registrar	_	Cei	rtificate of	Death		Reg. No.		
Physi		1. Decedent's Name (First, Middle, Las Helen Natomia			<u> </u>		2. Date of D Month April	Day -	Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give				Location of Death		4c. County		
Funera Directo		5. Social Security Number 6. Social Security Number 214-16-0422	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D March	irth 14, 1922	9. Birthp Coun Mar	place (State or Foreigntry) yland
death with the Maryland ms 23a or 28a-f show must be notified at	ctor	10a. State 10b. County Maryland Frederi		ty, Town or Lo	cation Frederick	:			1	0d. Inside City Limits 1 XYes 2 □ No
th with the 23a or 28 ist be no	al Director	10e. Street and Number 218 West Fifth S	Street		10f. Zip Code	21701		10g. Citizen of What Country? United States		
le le	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		e - Americ ck, White, v: Wh	
be filed within 72 hours aft ttal Hygiene. d other than "natural", or event, the Medical Exami	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	i (Give	dent's Usual Occup kind of work done DO NOT use retired Secret	during most of wor d)	king	16b. Kind of Bi	usiness/ind	•
should be filed valued with the filed valued was the filed value with the filed value in marked other in matic event, the	To Be Co	17. Father's Mame (First, Middle, Last) Martin L. Gre	en	<u> </u>	Decret	18. Mother's Nam		e, Maiden Surnan 1 Siebert	ne)	
and 2 should half half half half half half half half		19a. Informant's Name/Relationship (7 Mary Groff / Nie			ng Address <i>(Street</i> 47 Hall F					
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Mou	nt Oli	sition (Name of matory or other place vet Cemet	20 Ery			.ck, 1	Maryland
Departing Depart	5	21. Signature of Funeral Service Licen	M014	.33 22	2. Name and Addre	ss of Facility K Inch Street	eeney & 1 , Freder	Basford P. <i>i</i> ick, Maryl	A. Fun and 21	eral Hone .701
w requires that the death certificate be executed we require that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	E I	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence). Due to (or as a consequence).	uence of):	AL f	PAILUR	iter.	(Dise	45E-	Onset and Death
the death certify the attending ched for use as	ician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3□	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
The law requires that the death the has been signed by the attengage 2 should be detached for un	ed by Phys	Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		tobacco use cont	ribute to th	he cause of death?
2 8 2	Completed	07 W					per 1⊡ Yes	opsy formed? 2 No		psy findings available mpletion of cause of 2 No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	4 Mursing H	ome 5 Res	one) sidence 6 □Oth how injury occur (Street and Numbown, State)	red	
the Hospit in 24 hour the Funera	Medical (one) 2 Medical Exam	yslcian: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the til vestigation, in my o	ne, date and place pinion, death occu	, and due to the	e cause(s) and ma e, date and place,	inner as si and due to	tated. o the cause(s)
To To	Z	29b. Signature and title of certifier			29c. Licens			29d. Date signe		
	toto	36- Name and address of person who of SIBTE A KAZ 31. Date filed (Month, Day, Year)	completed cause of death (Item H) 810 32. Registrar's Signa	4 10	Print) Ho	use A	ue fr	LEDERIC	CK.	1008 Mn 2170
Regis	tate trar	APR 2 5 2008			2 5					

State Registrar DHMH 17 Rev 1/2001

Columbia

Months

Age (In yrs. last birthday)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.

3. Time of Death

20:55 M

Birthplace (State or Foreign Country)

4c. County of Death

Howard

8. Date of Birth (Month, Day, Year)

4a. Facility Name (If not institution, give street and number)

5. Social Security Number

Howard County General Hospital

1 □ M 2 🗓 F

137-56-3151 Sept 13, 1963 Thailand Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Clarksville 1 ☐ Yes 2X No Howard Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5715 Adams Way 21029 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Remo Ray Garufi Carmela Elisa Contillo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roderick Redman/husband 5715 Adams Way Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 04/12/08 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 2 He MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Breast Adenocarcinoma 47/21/21 resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed Failore Jaundice 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy: within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30573 April 10,2008 ari 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OB Little Patoxent Parkwail 9 11065 31. Date filed (Month, Day, Year) 32. Registrar's Signature NO State Registrar

08-03056 SA Richard Knight Ga	ardi	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H		ible.	5 ·
	1 F	- For State Certificate of Death	Re	g. No. 200	18 1359
Physician Medical Examin	er	1. Decedent's Name (First, Middle,Last) Richard Knight Gardiner	April 19, 20	Day Year 008	3. Time of Death 1509 hrs
	ľ	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 40121 Little Woods Lane St. Mary's	1	4c. County of Deat St. Mary's	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 51 Yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min		n (MM/DD/YYYY) 9. Bi Forei 1957	rthplace (State or gn puntry) Maryland
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	ector	Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral Director	40121 Little Woods Lane 20650 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S 14. Whener Married 2. Armed Forces? 15. Was Decedent of Hispanic Origin? (S 16. Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	United Sta 14. Race - Ame White, etc.	tes rican Indian, Black,
ifter death	by Fun	1 Never Married 2 Married 2 Married 1 Yes 2 No specify:	rican, etc.)		hite
72 hours a	eted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business	/Industry
and 2 should be filed within 72 hours after teath and Mental Hygiene. teath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner.	Completed	17. Father's Name (First, Middle, Last) Manager 18. Mother's Name	e (First, Middle, M	Country C	lub
21215 auld be filk Mental H marked c	å	William Greenwell Gardiner Suz: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	anne Kni		te, Zip Code)
MD should show all the and seen 27 is remartie		William G. Gardiner, Jr./Brather 40121 Little Woods La		-	MD 20650
altimore, MD mit. Pages 1 and 2 sh ppartment of Health an pportant: If item 27 i jury or other trauma	I	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Brinsfield-Echols Cr. A-2	/ 2008	Charlotte	Hall MD
Balt permit. Depart Import injury	-	21 Spector of Fund Force Leansee 22. Name and Address of Facility Bri Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd.	insfield Leona	Funeral H	ome, P.A.
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	اي	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			
cecuted and - transit	Examin	Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
0, be execute sician and burial - tra	edical	TYUNPENDED AMENDED, 28a-f mperME, g879 5/15/08 TT			
Signation of	sician/I	IF FEMALE: 23c. If yes, outcome of pregnancy 1	ancy	23d. Date of delive	ery Day Year
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute	o the cause of death?
cords, I	Completed		24a. Was autop	an 24b. Were sy prior to death?	autopsy findings available ocompletion of cause of
Vital Rec	Be Co	25. Was case referred to medical examiner?	1 Yes	2 No 1	Yes 2 No
of Vit	위	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nurs 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?		Residence 6 🗸 Oth	ier: Scene
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should t	Certification:	Natural Accident Accident Suicide Suic	unk 28f. Location (S	Street and Number or l	Rural Route Number, City
he Hospital in 24 hours : ire Funeral	edical Cert	4 Homicide determined (Specify) unk 29a. Certifier (Check only) one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the caus	se(s) and manner as st	
To the within To the company	Med	and manner stated. 29c. License number		29d. Date signed (A	
		O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)	4204	April 20, 2008	
		Zabiullah Ali, M.D. Assistant Medical Examfiner 111 Penn Street, Baltimore, MD 2 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	1201		
Registr	ar	APR 2 3 2000 Bleeve to Speck	OCME		

ORIGINAL

08-02931 Jonathan McGra	th H	Please Type or Print in Black Indelible Ink State of Maryland / Department of H			ble.	
		- For State Certificate of D		Reg	. No. 201	10 1000
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death	lun w	3. Time of Death
Medical Exami		Jonathan McGrath Harlow 4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death	April 14, 20	08 4c. County of Death	1549 hrs
1			Crofton	'	Anne Arundel	
Funeral		3 . ,	f Under 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Birti Foreig	
Director		220-17-2936 1XM 2 F 31 Yrs.	Months Days Hours Min	6/2/19	76 Co.	intry) MD
ų,	- н	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
How any		MD Anne Arundel Crofton				1 Yes 2xx No
Maryland 28a-f show	Director	10e. Street and Number 1	0f. Zip Code	100	. Citizen of What Cour	try?
the M		1600 A West Bancroft Lane	21114		USA	
t be n	Funeral	1 V Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
er dea		1 Yes 2 X No	es 2 X No specify:		Specify: W.	hite
ours afi	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of		16b. Kind of Business/I	
6 72 ho an "na ical Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use ret	urea)	D 11- 1	VE 1 - 1.1 - 1.1.1
-003 Lwithii giene. her th	E O	1.2 COTISE I	uction 18.Mother's Name	e (First, Middle, Ma		Midatlantic
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Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	۵	1,111	ddress (Street and Number or			, Zıp Code)
and 2 s ealth a em 27	H	Judy Harlow Mother 2488 Hi		ofton, MD	20c. Location - City or	Town, State
nore gesla tof H		1 Burial 2 X Cremation 3 Removal from State crematory or other	place)		Baltimore,	
Baltimore, permit. Pages I an Department of He Important: If ite	ŀ	4 Donation 5 Other Specify:	ne and Address of FacilityHar			
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	ine	if any, leading to immediate cause. Enter Underlying Stause C. Due to (or as a consequence of): C.				
ed Isit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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687 certific	ian/	past 12 months?	death 3 Ectopic pregn	nancy	Month (Day Year
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Division of Vital Records, tal or Attending Physician: The law requirers after death. "I Director: After this certificate has been sited in by the funeral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Othory		Residence 6 🗸 Othe	r: Scene
n of ing Ph After t funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day,Yeer) 28b. Time of Injury		28d. Describe h	ow injury occurred	
IVISIOR or Attend after death Director: in by the	catic	2 Accident Investigation Fnd 4/14/08 Fnd@ 3:30p		Unk	troot and Number or Pi	ural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined Specify) Found at Residence	actory, office building, etc.	or Town, St		
Di Hospital 24 hours a Funeral tely filled	<u>a</u>	29a. Certifier Check only Certifying Physician: To the best of my knowledge, death occurrence of the best of my knowledge.	d at the time, date and place, an			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: of the basis of examination and/or investigation and manner stated.		at the time, date a		
0.0.0	3	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo	ntn, Day, Year)
180		30. Name and addisss of pason who completed cause of death (Item 23a)	J.J.IVI.L.		7 pm 10, 2000	
OCME		1/ /	Penn Street, Baltimore, 1	MD 21201		
	ate	31. Date filed (Month Day, Year) 2008 32. Registrar's Signature				
Regist	rair	THE TOTAL POPULATION OF THE PARTY OF THE PAR				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 13592

		1 - For State Registrar	State of Ivi			rtificate				Reg. No.	008	13592
Physic		1. Decedent's Name (First, Middle, La MILTON COLVIN HO							2. Date of D Month APRIL	Day 8	Year 2008	3. Time of Death 7:50 A ^M
/Med Exam		4a. Facility Name (If not institution, gi				4b. City, T	Town, or	Location of Dea			nty of Death	7:30 **
		ANNE ARUNDEL MED	CAL CENTER	R			ANNA	POLIS		ANI	NE ARUN	NDEL
Funera			Sex 7. Ag 1 X M 2 ☐ F	e (In yrs. las		If Under 1 Months	1 Year Days	If Under 24 Hr Hours Mir	(Month, I	Birth Day, Year)	Coun	ace (State or Foreign try)
Directo		308-38-8154 Usual Residence of Decedent		68	Yrs.				APRIL	13, 1939	MASSA	CHUSETTS
yland now		10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits
e Mar	ctor	MARYLAND QUEEN	ANNE'S			QUEEN	ISTOV	/N				1 X Yes 2□No
iff th	Directo	10e. Street and Number				10f. Zip (Code			10g. Citizen o	of What Coun	try?
s 23a	era	177 RIVER RUN	T.0.11.		140.1		216				D STAT	
fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Armed Forces? 1 XYes 2 I		- 13. 1	If Yes, speci	ify Cubar	n, Mexican, Pue	Specify Yes or North Rican, etc.)	NO- 14. F	łace - Americ łack, White, e	
Id Z IZ IS-UU30 filed within 72 hours after death with the Maryland I Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Modeal Exercitive must be recitied at	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1962		1∐Yes 2	No	Specify:		Spei	cify: WHI	TE
Z15-U	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual kind of work	k done di	uring most of we	orking	16b. Kind of	Business/Ind	ustry
727 within ene. than "	m	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use TOMOL (FEDER	T COM	PDMMPN''
d Z1 filed wi Hygier other th	Φ	17. Father's Name (First, Middle, Las			EN	TOMOLI			ame (First, Midd			ERNMENT
lan lid be Mental rked o	To B	FREDRIC HOLMES					-	KATHE	RINE SP	INNEY		
Maryland d 2 should be file th and Mental H; 77 is marked oth traumatic event	1	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address ((Street a	nd Number or I	Rural Route Num	nber, City or Tov	vn, State, Zip	Code)
		KATHRYN HOLMES/WI	FE		177 F	RIVER	RUN,	QUEENS	TOWN, M	ARYLAND	21658	
of H of H fite		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [☐Removal from State	20b. Pla	ce of Dispo netery, cren	sition (Name natory or oth	e of her place	AP	RIL 9	20c. Locatio	n - City or To	wn, State
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baltimo permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Lice	ns.	E Les		LLOWS 06 SHA	, HE	LFENBEI	N AND N	EWNAM F	UNERAL LAND 2	HOME, P.A. 1619
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oo / ou, ficate be executed physician and s the burial-transit	Medical		d									
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BOX leath cer attendir	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	eath 3	Ectopic pre					Date of delive Month	ry Day Year
at the c d by the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown									
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equire equire sen si ould b									. 1	Yes 2□No	3 Prob	ably 4 ☐ Unknown
ne law requires to has been signed ge 2 should be considered.	Completed								24a. Wa	is an 24	b. Were autop	osy findings available inpletion of cause of
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To the Hospital or Attending Physician: The law requires that the death cen within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner sta	of examination	n and/or in	vestigation, i	in my op	inion, death oc	curred at the time	e, date and plac	e, and due to	tated. the cause(s)
Fo the within Fo the compl	Me	29b. Signature and title of confiler		A		29c.	License	number		29d. Date sig	ned (Month, I	Day, Year)
6,		> 31 pt	wish.	, MD			D	14605	2	4/60	108	
10		30. Name and address of person who so that the control of the cont	completed cause of d	leath (Item 2	(Type	Print)	NAU	, Ann	apolis,	MU 2	1401	
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State of Maryland / Department of Health and Mental Hygiene

Г	Funeral
	Funeral Director
■ Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, the Medical Examiner must be notified at once.
	Physician /Medical
	/Medical

Examiner be executed ng physician and as the burial-tran Box 68760. attending physician ō signed by the a d be detached f P.O. Division or Vital Records, been si should I page 2 s funeral director, this I or Attend after death Director: To the Hospital or Atte.

within 24 hours after de
To the Funeral Direct
completely filled in by th

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CHARLES R. HERTZBERG APRIL 7, 2008 3:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2 □ F 229-32-9693 01/29/1931 NEW YORK 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY GERMANTOWN tX Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17408 SIEVER COURT 20874 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 11XT Yes 2 □ No If Yes, Give Year or Dates: KOREAN 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify:WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SENIOR EXECUTIVE SMALL BUSINESS ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH MILLER HERTZBERG SARAH ZIMMERMAN HERTZBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS E. HERTZBERG/WIFE 17408 SIEVER COURT, GERMANTOWN, MARYLAND 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State JUDEAN MEML GARDENS 4 ☐ Donation 5 ☐ Other (Specify) 04/10/2008 OLNEY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA MINUTES Due to (or as a consequence of): b. SEPSIS 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner c METHICILLIN RESISTANT STAPH AUREUS 1 MONTH Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1≹ Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) DO065429 April 07, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. THOMAS HSING-TEH WANG, 15525 SHADY GROVE RD, SUITE 201, ROCKVILLE, MARYLAND 20850

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR

1 1 2008

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 594 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RUTH E. HAYES APRIL 2008 9:10AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE TALBOT EASTON 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Months Days Hours Min 89 MARYLAND Director 216-03-1417 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1**y**Yes 2□No Director EASTON MD TALBOT death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 MECKLENBURG AVE. 21601 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene s marked other than Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL 12 OFFICE MANAGER permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CRESTON JACKSON RUTH ENSOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 SOUTH AURORA ST., EASTON, MD 21601 DURRIE HAYES/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 4/4/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 MOHN R MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Oneumania /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Po Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2; autopsy perform certificate Division or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 □ N 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospitai or Attending 5 ☐ Pending investigation 1 Natural Injury 4 hours after death.
Euneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Dires. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 W Frances 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURGOYNE, M.D. 510 IDLEWILD AVE., EASTON, MD 21601 MARY B. 31. Date filed (N State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Year O3 DM ELMA EDITH HERRELL 3200 /Medical loral 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lions Center Allegany Cumberland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X F 236-62-6066 91 Director West Virginia Dec. 4, 1916 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director WV 1x Yes 2 No Morgan Paw Paw 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Winchester Street 25434 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Effie Shanholtzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis E. Herrell Son P. O. Box 484 Paw Paw, WV 25434 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State 04/16/2008 4 Donation 5 Other (Specify) Woodrow Cemetery Paw Paw, West Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kimble Funeral Home 188 Mosser Avenue Paw Paw, West Virginia 25434 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 24V5 **Physician** disease or condition resulting in death) oyona /Medical Due to (or as a consequence § Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 1 ☐ Yes 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has autopsy perforn 2 No 10 25. Was case referred to medical 26. Place of Death Check only one) examiner? Hospital: 1 ☐ Yes 2 🕱 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Vatural 5 ☐ Pending investigation Injury 2☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral I Hospital 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of beiti 29c. License number

Sic

DHMH 17 Rev 1/2001

Registrar

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:26 AM ENNETH PRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARK Mont Gom ERY

9. Birthplace (State or Foreign Country)

MD WASHINGTON AKOMA HOVENT151 HOSPITAL Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 7, 5. Social Security Number Age (In yrs. last birthday, If Unde Months **Funeral** 1 XM 2 ☐ F 78 Director 215 24 8648 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sh edical Examiner must be notified 1 ☐ Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21042 United States 10240 Fairway Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1949–55 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Gas Pipeline Department of Health and Mental Hy, Important: If Item 27 Is marked other any Injury or other traumatic mense. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Ruth Miller Jesse Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Marie Hall/Wife 10240 Fairway Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-15-2008 Poplar Springs Cem. Mt. Airy, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician 24 /Medical Due to (or as a consequence of): Examiner ERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed ISCODGED GASTROSTOMY as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE for use a If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 HEART 1 ☐ Yes 2. No 3 Probably 4 Unknown Completed RENAL 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No FAILL 24a Was an certificate has 1□ Yes 2₩ No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No r death. Hospital or Attendi 24 hours after death. Funeral Director; A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltimore, Maryland 21215-0036

Box 68760.

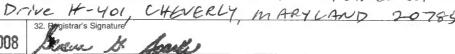
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Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) APR 14 2008

HOSPITAL

29b. Signature and title of cortifie



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D0057649 BRYAN M. 29d. Date signed (Month, Day, Year)

STEINBERG

APRIL 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3597 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month ANNE 07:00 AM City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE JOHNS HOPKINS HOSPITAL None If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 068 54 1497 41 Taiwan 11-4-1966 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5905 Quiet Ways Court 21029 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 3 ☐ Widowed 4 ☐ Divorced <u>Asian</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Li Peng Keke Shanpo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce R. Hart/Husband 5905 Quiet Ways Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 4-12-2008 | Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Knoll 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final disease or condition resulting in death) r as a consequence (f) 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

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signed by

page 2 certificate has

funeral director.

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completely

24 hours a Funeral L

To the within 2

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Certification:

Medical

requires that the death certificate be executed

P.O.

Records,

or Vital

Division Hospital or Attending **Physician**

Examiner

Funeral

Director

28a-f show

Items 23a or 28a-f show Iner must be notified at

r than "natural", or Items 23e the Medical Examiner must

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "no any injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

MD

/Medical

Examine Physician/Medical þ Completed Be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performe res 2

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death Natural Accident

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year)

MEDICA DOCTOR

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number RES - 000

29d. Date signed (Month, Day, Year) APRIL 11, 2008

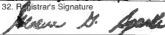
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZIKUIJKA LUHOT, MICHELLE HIPKINSHOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year)

State Registrar

APR 14 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Marylan State Registrar	•	rtificate of L		, ,	eg. No.2 0 0 8	13599	
	Physicia	an.	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death	
	/Medic	al	William Melvin Hamerdi	nger	4. 65. 7		April	13, 2008	6:50 PM M	
	Examin	er	4a. Facility Name (If not institution, give street and number) Oakland Nursing and Rehab Cent	er		Location of Death		4c. County of Death		
10	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign ntry)	
	Director		578-07-9489 ¹ X № 2□F 94	Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 5,	1913 Wash	ington, DC	
	and ow t		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits	
	Mary Fied a	tor	MD Garrett		0akland				1 □Yes 2 K No	
	th the or 28s	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?	
	23a c 23a c ust b	ral	2658 Steyer Mine Road			21550		USA		
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Was Decedent of His f Yes, specity Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,		
2	irs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWI	r 1	1□Yes 2XNo	Specify:		Specify: W	hite	
5	be filed within 72 hours after death with the Maryland thygiene. A thygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a, Deced	fent's Usual Occupa	ation Juring most of worki	na I	16b. Kind of Business/Ir	dustry	
7	/ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	- life. L	kind of work done d DO NOT use retired, Examiner		I .	M		
7 7	filed v Hygie ther t		11 17. Father's Name (First, Middle, Last)		Examiner	18. Mother's Name		Municipal G Maiden Surname)	overnment	
0	ld be ental ked o ic eve	To Be	Harry Randolph Hamerd	inger		Etta	Viola	Raitz		
<u> </u>	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)		g Address (Street a			City or Town, State, Zi	Code)	
Ě	and 2		Susan V. Simmons/ Daughter				0aklan	d, Maryland	21550	
ם כ	of He		20a. Method of Disposition 20b. F	Place of Dispos cemetery, cren	sition (Name of natory or other place	e) [Date 2	20c. Location - City or T	own, State	
aitillio	t. Pag tment tant: tant:		4 □ Donation 5 □ Other (Specify) Che		m MD Vet'	1	1	Cheltenham		
ם ם	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. In the Marylan Important: If Item 27 Is marked other than "natural" or items 23a or 28a-s' show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ligense		. Name and Addres tewart Fu	•		. Second St and, MD 21	• 550	
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Dact	ferial	neuma	mia		Onset and Death Weeks	
	/Medical Examiner		Due to (or as a conseq	uence of):	COPD			4	ens	
	pe tis	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uende of):	J					
	xecut and al-tran	хап	that initiated events resulting in death) Last	uence of):						
00/00	eath certificate be executed attending physician and for use as the burial-transit	calE	d							
9	rtificat ng phy as th									
2	ath ce ttendir or use	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnate in the past 12 months?		Ectopic pregnancy			23d. Date of delivery Month Day Y		
5	he dear the ar	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ieath 5□	Other (specify)			Wolfel	Day Year	
ŗ	that the post of t	y Phys	Part II. Other significant conditions contributing to death but not res	ulting in the un	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	he cause of death?	
	w requires that the de been signed by the should be detached	Completed by	Past Smoking				1 5 /Ye	s 2□No 3□Pro	pably 4 ☐Unknown	
ב ט	iaw requir as been si 2 should	plet					24a. Was ar	24b. Were auto	ppsy findings available impletion of cause of	
	The ate has page	Eog					perform	ned? death? No 1 ☐ Yes	2X No	
2	clan: certific ector,	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one	9)		
5	Physic this cral din	2	1 Yes	ER/Outpatient		4 Nursing Ho		nce 6 Other (Speci	fy)	
5	rding th. : After	Certification:	Natural 5 Pending (Month, Day Year)	? /es 2□No	zod. Describe no	w injury occurred				
1								reet and Number or Run	al Route Number,	
5	ital or rs afte ral Dir led in	Cert	-				City or Town			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my known and manner stated.	wledge, death ation and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner as sate and place, and due	stated. to the cause(s)	
	To th To th	Ž	29b. Signature and title of certifier	M A	29c. License	number	29	d. Date signed (Month,	Day, Year)	
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		1/4	30 Name and address of person who completed cause of geath (Iten	n 23a) (Type, F	Print)	N. LH	K < 1	C+ 1 2	nklandind	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar Signa	ature	033	, - (31,	SIC 1 ()	DESIG	
	Registr		APR 1 5 2008	B A	south of				0.500	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Physician 5, 4:00 p. ^M April William 4 1 **Hamalainen** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Golden Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**ॼ** M 2□ F 62 016-34-0912 Feb 26, 1946 Massachusetts Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at Maryland 1 Yes 2K No Frederick Middletown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 21769 USA 7100 Crystal Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∰ Yes 2 □ No If Yes, Give 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2x Married white Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Home Depot Contract Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Grace Graves** Uno Hamalainen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Hamalainen - Wife 7100 Crystal Court, Middletown, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXurial 2 □Cremation 3 □Removal from State 4-9-2008 Frederick, Maryland Mt. Olivet Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CELL mary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner month if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed aftending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No the detached 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ þe 4 Conknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a Was an autopsy performed? (es 2 2 No has certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: After (Month, Day Year) Injury Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760. Division or Vital Records, e Hospital or Attendi 24 hours after death, e Funeral Director: A To the Hospital within 24 hours at To the Funeral C

0 4+1

State Registrar

Medical

29a. Certifier

29b. Signature and tifle of certifier

Pace House Aut-Frederick MD 21701 MM Registre's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

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			State Registrar	Cert	titicate of l	Death	R	eg. No.			
		φ.	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day	Year 3.	. Time of Death	
	Physicia		BETTY LOU HERNDON				APRIL 4		real .	12:30 P M	
	/Medic				4b. City. Town, or	r Location of Death	1	4c. County			
4	Examin	er	43 Facility Name (If not institution give street and number)		•	NTREVILLI	7	QUEEN ANNE'S			
			HOSPICE CENTER 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1			
г.	Funeral		1 M 2 T F		Months Days	Hours Min.	(Month, Day	, Year)		e (State or Foreign	
	Director	į.	579-58-9924	65 YIS.			JAN. 23	, 1943	MYSUTN	GTON, DC	
	p ,		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loc	ation				10d.	Inside City Limits	
	aryla shov d at	_	100.000.00							1X Yes 2 No	
	e Ma-f	cto	MARYLAND QUEEN ANNE'S		CHURCH	HILL					
	th th	Directo	10e. Street and Number		10f. Zip Code		'		What Country?		
	h wi		216 LAYSAN TEAL COURT		2	1623		UNIT	ED STA	TES	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	/er in U.S. 13. W	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Ra	ce - American I ck, White, etc.		
10	fter r Ite	교	1 □ Never Married 2 □ Married 1 □ Yes 2 📉 N)	☐ Yes 2 K No		, , , , , , , , , , , , , , , , , , , ,		AMER		
ဗ္ဗ	al",o	b	3 ☐ Widowed 4 █ Divorced If Yes, Give Year or Dates:	'	Li res Zasino	Specify.		Speci	y INDIA	AN	
21215-0036	2 hou	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occur	ation	lain a	16b. Kind of E	Business/Indust	try	
15	in 7.	ple	(Specify only highest grade completed)	ilife. D	Kind of work done OO NOT use retired	during most of work d)	Kilig				
7	with ene.	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+	NUCLEA	R MEDICI	NE TECHNI	ICIAN	H	ALTH CA	ARE	
	iled Hygi Ither nt, t		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surna	me)		
Ĕ	be ntal	Be	JOHN HERNDON			DOVIE 1	LOCKLEAR				
Maryland	should and Men s marke umatic	မ		405 M-35-	- A dalance /Canada			. City or Town	State Zin Ce	ada)	
ā	2 sh and Is r		19a. Informant's Name/Relationship (Type. Print)		•	and Number or Ru					
	and ealth n 27 ier tr	17	DOVIE METZGER/DAUGHTER			AL COURT					
altimore,	一工品を	- 0	20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	20b. Place of Dispos CHESAPEAK		FON ADD	Date	20c. Location	- City or Town,	, State	
Ē	Pages nent of nt: If its iry or o		4 □ Donation 5 □ Other (Specify)	CENTER	E CKEPIAI	TON AFK	^{[L} 5 2008 S	TEVENS	VILLE.	MARYLAND	
≣	nit. I		21. Signature of Funeral Service Licensee		. Name and Addre	ess of FacilityFEL AND_FUNE	LOWS, HE				
Ba	permit. Departr Importa any Inje		Will Eromen MO	0672 CR	EMATION	AND FUNE POLIS, MA	RAL CARE	31/01·	, 814 B	ESTGATE	
			23a. Part1. Enter the disease, or complications that caused						Ar	pproximate	
			shock, or heart failure. List only one cause on each lin-	9.		3 ,			Int O	terval Between nset and Death	
ST.	Physician		Immediate Cause (Final disease or condition PANCREAT	IC CA					6 1	MONTHS	
4	/Medical		resulting in death) Due to (or as a	consequence of):							
le.	Examiner		b								
	,et	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):							
	uted i ansit	Examiner	Cause. Enter Oridenying Cause (Disease or injury that initiated events C.								
	al-tra	Xa		consequence of):	f):						
9	be e iciar burt										
68760,	cate phys	dic	d								
9 ×	certificate be executed iding physician and ise as the burlal-transit	/Medical	IF FEMALE: 23c. If yes, outcome	of pregnancy				20d D	ate of delivery		
Вох	attend I for us		23b. was decedent pregnant	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	y			ate of delivery fonth Da	ay Year	
	e de	sic	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	time of death 5L	Other (specify) _						
P.0	res that the death signed by the atten be detached for u	Physicia	9 Unknown				00. 8:14		- 4-1h - 4- 4h -	and the same	
	s the	by F	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause giv	ven in Part I.				cause of death?	
ğ	quire n sig ald b						10`	res 2 No	3 Probab	ly 4 □Unknown	
00	law requires as been sign 2 should be	Completed					24a. Was	an 24b	. Were autops	y findings available	
3e	has has	효					autor perfo	osv	prior to compl death?	letion of cause of	
=	: The cate had page	ပိ						rmad? 24 No	1 ☐ Yes 2	□ No	
or Vital Records,	Physician: The this certificate had director, page	Be	25. Was case referred to medical examiner? Hospital:			26. Place of Dea	ath (Check only o	ne)		HOSPICE	
1		ြို	Timpatie	nt 2 ER/Outpatien	IL SO DOA	her: 4 \sum Nursing H	lome 5 ☐ Resid	dence 6 X O	ther (Specify)	HOUSE	
0			27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day	y 28b. Time of <i>Year)</i> Injury	f 28c. Inju Wo	iry at ork?	28d. Describe I	now injury occu	irred		
0	affr. r: Af e ful	랿	2 ☐ Accident investigation		M 1 □]Yes 2□No					
/is	Attending r death. ector: After sy the fune	fice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju	ry - At home, farm, str	eet, factory, office		28f. Location (S		nber or Rural R	Route Number,	
Division	after Dire	Certification:	4 ☐ Homicide determined building, etc	. (Ореспу)			Only of 101	m, otato)			
	Hospital 4 hours a Funeral tely filled		29a. Certifier 1 X Certifying Physician: To the best of	f my knowledge, deatl	h occurred at the t	time, date and place	e, and due to the	cause(s) and i	nanner as state	ed.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place	∌, and due to th	he cause(s)	
	To the within 2 To the comple	Vec	29b. Signature and title of certifier,	•	29c. Licen	se number		29d. Date sign	ned (Month, Da	ay, Year)	
	5 × 5 0	N	250. Signature and time of common		729	200			14/08		
	200	1	burat 2/m/o		1771	00/		41	7/00		
	400		30 Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)	11.11	1151	- (11	1. 1.	
	Ma		David It. Smith 6	602 C	hurch	14:11	d. St.	100	nest	tertour,	
	St	ate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	1				MA		
	Regist	rar	APR 1 0 2008	r's Signature	and a				100		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Kevin Joseph Hollan	d State	e of Maryland	/ Departmen			d Menta		Don No	20	18 1360
Physician/	Registrar 1. Decedent's Name (First, Middle,L	ast)					2. Date of De			3. Time of Death
Medical Examiner	Ke 4a. Facility Name (if not institution, g	vin Joseph		Lab	. City, Town, or	Location of	Month March 9,		Year County of Deat	1345 hrs
1	206 Gray Fox Court	give street and number)	4.	Edgewater	Location of	Deali		nne Arunde	1
Funeral	Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birthda	ay)	If Under 1 Yea			irth (MM/D		rthplace (State or
Director	213-04-3705	X M 2 F	40	Yrs.	Months Day	rs Hours	Min. 06/2	5/196	7 0	⁹ⁿ Washington, D.C.
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Locatio	n					10d. Inside City Limits
bo and	Maryland Anne A	rundel	Edge	ewat	er					1 Yes 2 X No
the Maryland R or 28a-f sh lifted at once	10e. Street and Number				10f. Zip Code			-	en of What Co	untry?
h the N 3a or 3 otified	206 Gray Fox C	t			21037				USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Marri	12. Was Deceden	?				n? (Specify Yes or N Puerto Rican, etc.)	10-	 Race - Ame White, etc. 	rican Indian, Black,
her de		ed If Yes, Give Year	2 X No	1 1	Yes 2 X N	specify:			Specify: Whi	te
ours al atural xamin	15. Decedent's Education (Specify	or Dates: only highest grade co			s Usual Occupa		ind of work done	16b. K	ind of Business	/Industry
0036 within 72 hours after giene. Medical Examines ompleted by	Elementary/Secondary (0-12) 12th	College (1-4 or	5+)	•	ager		,		Retai1	
21215-0036 build be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, La	est)		riar	agei	18.Mother's	Name (First, Middle			
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10re ages 1 nt of H it: If in	1 X Burial 2 Cremation		Gate of		_{er place)} eaven Ce	-m-	3/14/08	Si	lver Si	oring,MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If iter Injury or other tr	4 Donation 5 Other Special Service Lice	ensee	Toute of				George P			
E.E.E.	Mand o'clack			297	3 Solon	ons I	sland Rd.	Edge	water.	MD 21037
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xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Seizure Dis								1
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x 68 h certif ending use as	past 12 months?	1 Live birth 4 Pregnant a	at time of death 5		aldeath 3 ner (Specify)	Ectobic	pregnancy		WOTE	Day Teal
by the attentiched for us	1 Yes 2 No 9 Unkno	9 Olikilowii				-b	# L 220 Di	d tobacco	uso contribute	to the cause of death?
P.O. es that the igned by the detacl	Part II. Other significant condition	is contributing to dea	ath but not resulting i	in the ui	nderlying cause	given in Pa			_	robably 4 V Unknown
Records, The law require fitcate has been sig. page 2 should b. Completed							24a. W			autopsy findings available o completion of cause of
Records, The law require ficate has been si, page 2 should b				_				tapsy rformed? s 2 N	death	?
Vital Records, P.O. Box 68766 sistems. The law requires that the death certificate his certificate by the attending phy director, page 2 should be detached for use as the observed.	25. Was case referred to medical				26.Pia		(Check only one)			
of Vitaling Physician: After this certion control of the coordinate of the coordinat	examiner? 1 ✓ Yes 2 No		tient 2 ER/Out			Other ₄	Nursing Home 5		ence 6 🗸 Oti	ner: Scene
n of \ding Phy. h. After tl funeral	27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Ir (Month, Day	njury 28b. Ti (Year)	me of Ir		jury at Work Yes 2		e now inj	ury occurred	
Division tal or Attendin rs after death. al Director: // led in by the ft.	2 Accident Investig	gation 28e Place of	Injury - At home, farr	m, stree			_	n (Street a	and Number or	Rural Route Number, City
Division o ospital or Attending hours after death. Inneral Director: Afty filled in by the fune Certification:	3 Suicide 6 Could redeterm	lot be					or Town	n, State)		
9 - 5 9	29a. Certifier 1 Certifying Physical Cone)	sician: To the best of ner:On the basis of ex	my knowledge, death	h occuri	red at the time,	date and pla	ace, and due to the c	ause(s) ar	nd manner as s	tated.
To the III within 24 To the Ft completed	29b. Signature and title of certifier	and manner state	d	resugau		nse number	corres at the time, or			Month, Day, Year)
	Pot . O. ma	- Pa	20.2 4	2		C.M.E.			rch 10, 200	
	30. Name and address of person w									
(1000	Patricia Aronica-Pollak		Medical Exami	ner	111 Penn :	Street, Ba	altimore, MD 21	201		
State Registrar	31. Date filed (May (LAPey, Year)	ZUU8 32. egist	rar's Signature	do	the same					
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			State Registrar		,	Certific	ate of	Death		Reg. No.	2008	13604	
	Physici	e an	1. Decedent's Name (First, Middle, Las					-	2. Date of De Month April		2009 Year	3. Time of Death	
i.	/Medic		James Foward 4a. Facility Name (If not institution, give		•	4h C	ity Town	or Location of Dea			2008 County of Death	6:40p ^M	
1	Examin	er				40.0	-	deen	iu i		arford		
	Funeral		203 Edmund Stree 5. Social Security Number 6. S		(In vrs. la:	st birthday) If Ur	ADEL der 1 Year		s. 8. Date of Bir			lace (State or Foreign	
н	Funeral Director			M 2□F 7		Yrs. Mont	hs Days	Hours Mir	8. Date of Bir (Month, Da May 26	19, Year)	32 Cour	ntry)	
			Usual Residence of Decedent						1227 - 1		ALKa	nsas	
	yland		10a. State 10b. County		10c. City,	Town or Location					1	0d. Inside City Limits	
	A-f sh	호	Maryland Harford	1	Ak	oerdeen						1X Yes 2 □ No	
	r the	Director	10e. Street and Number			10f.	Zip Code			10g. Citiz	en of What Cour	ntry?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		203 Edmund Stre	eet			2	21001		U	SA		
	deal ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	. 13. Was De	ecedent of I	Hispanic Origin? (Specify Yes or No erto Rican, etc.))- 1	4. Race - Americ		
9	after or ite mine		1 Never Married 2 Married	1 Yes 2 No)		specify Cul. s 2 ⊠X o		no nican, etc.)		Black, White,		
8	ours ral",	by	3 Widowed 4 Divorced	Year or Dates: 5	3–73	TLITE	2 2 E E P 1 T U	эреспу.		3419	Specify: whi	te	
5	72 h natu dica	Completed	15. Decedent's Ed (Specify only highest gra	lucation	- 1	16a. Decedent's U	Jsual Occu	pation during most of w	orkina	16b. Kir	nd of Business/In	dustry	
2	ithin ne. Me	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retire	ed)	3				
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Maryland 21215-0036	d dal	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle		Surname)		
$\frac{8}{2}$	75 5 8 0	은	James E. Hayes,						ldred Wr				
a	C1 c0 '50 '60		19a. Informant's Name/Relationship (Type. Print)					Rural Route Numb			Code)	
	s 1 and if Health Item 27 other tr		Garnett Parker (d	laughter)					Aberdeen,				
0	ges 1 t of H If Itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ice of Disposition (metery, crematory	Name of or other pla	ice)	Date	20c. Lo	cation - City or To	own, State	
Ξ	Pa men ury		4 Donation 5 Other (Specify) Harford Memorial Gardens 4/21 Aberdeen, M									ryland	
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Lico	1SE 9		22. Name	and Addr	ess of Facility	rring_Cs	rao	Funoral	Home D A	
_	70 E # 9		1 19	sance		Abero	een,	Maryland	21001-3	3399	i diletar	Home, P.A.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death.	Do not enter the	node of dy	ing, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a. Recurred Due to (or as a	t As	spiration	Pne	monia	20 PA1	RKIN	SOMISA	Onset and Death 2-3 mmll	
1	/Medical		resulting in death)	Due to (or as a	conseque	ence of):				•		7 110110	
ā,	Examiner	.	Sequentially list conditions	D. PARKI	NSO	MZING	An	D. C.V	*. A.				
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Ď,	e exe ian a urial-		resulting in death) Last	Due to (or as a	conseque	ence of):							
68760,	ate b hysic	Medical		d									
	ertific ing p	Mec	IF FEMALE:										
ROX	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2			c pregnanc	су		2	3d. Date of delive		
	e de	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	ime of dea	ath 5 Other	(specify) _				Month	Day Year	
٦.	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/	9 ☐ Unknown										
Ś	res the igner	þ	Part II. Other significant conditions of	contributing to death but	not result	ting in the underlyit	ng cause gi	ven in Part I.			~	ne cause of death?	
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r	The ate had page	P O							perf 1∐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 □ No	
Vital	slclan: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of D	eath (Check only	/ ` —			
	Physic this ce al dire	일	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2□E	R/Outpatient 3	DOA Ot	her: 4 \Bursing	Home 5₺Res	idence 6	☐Other (Specia	(y)	
n o	or Attending Physician: after death. Director: After this certific in by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury	28c. Inju		28d. Describe				
000	endii eath. or: A he fu	atic	2 ☐ Accident investigation	1		М]Yes 2□No					
DIVISION	r Att er de lrecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	y - At hom (Specify)	ne, farm, street, fac	ctory, office			Street and	d Number or Rura	al Route Number,	
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	o the Hospital or Attendi ithin 24 hours after death. o the Funeral Director: A ompletely filled in by the fi		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of miner: On the basis of	my know	ledge, death occur	red at the t	time, date and pla	ce, and due to the	cause(s)	and manner as s	tated.	
	o the Hos ithin 24 h o the Fur ompletely	edical	one)	and manner stat	ed.					, date all	piaco, and due t	o me cause(s)	
		S	29b. Signature and title of certifier		4 0		29c. Licen	se number	1	29d Dat	e signed (Month,	Day Voor	

_oState Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02948 State of Maryland / Department of Health and Mental Hygiene Candace Kay Jackman Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 15, 2008 0736 hrs Candace Kay Jackman - Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Talbot Oxford 5833 Deep Water Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Country) Oregon Jan. 4, 1963 Director 541-98-8008 M 2 X X 45 Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 28a-f show Annapolis Maryland Anne Arundel iner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 3 23a or 3 21403 P.O. Box 4457 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Never Married XX Married 2 X X No Yes White Specify: Yes XX No specify: If Yes, Give Year Divorced Widowed "natural", 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours a
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natura
injury or other traumatic event, the Medical Examin Human Resources Information Completed Pharmaceutical College (1-4 or 5+) Elementary/Secondary (0-12) Industry Systems Manager 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Rose Victor Monger Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informants Name/Relationship (Type Print) Humperdinck Lionel Milton Maryland 21403 Annapolis, Box 4457 Husband P.O. Jackman 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/19/2008 | Baltimore, Maryland Baltimore Crematory Other Specify: Donation 5 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 Mich 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. a. Combined Drugs (Paroxetine, Flurazepam, Quetiapine, & Lorazepam) Intoxica Death A dical ion Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/29/08 amh X UNPENDED attending physician for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FFMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for Unknown ned by the a detached fo Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 ✔ Unknown signed b ģ σ. Completed 24b. Were autopsy findings available Records, ficate has been si page 2 should b 24a. Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 1 🗸 Yes After this certificate I 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Division of Vital Be Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: examiner? Inpatient 2 FR/Outpatient 3 1 🗸 Yes ပ No 28d. Describe how injury occurred 28c. Injury at Work 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 X No 1 Natural <u>Subject overdosed on drugs</u> 5 Pending Fnd 4/15/08 Fnd 6:15a e Funeral Director: etcly filled in by the 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 5833 <u>Deep Water Dr., Oxford, Talbot Co., MD</u> Town, State) 3 X Suicide determined (Specify) Found on a boat in river 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie April 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD are Signature 32. Reg 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 ear Month 10:50 PM April 13, JOY Floyd Theodore 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Hagerstown Ravenwood Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 14 M 2 □ F Months Days Hours Yrs. 93 Dec. 16,1914 Maryland 203-10-3384 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Hagerstown Maryland Washington County 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21740 1158 Luther Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Defense Contractor Machinist 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cora Miller Arlington Joy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elaine Holler-daughter 15601 Wild Rose Ct. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 4-17-2008 Clear Spring, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaitlin taren 23a. Part1. Enter the disease, or-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleusis Vecas Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient ASSISTES Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 ☐ No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 Tyes 2 🗌 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide

Examiner Examine and il-transit The law requires that the death certificate be executed physician at s the burial-1 Box 68760. Physician/Medical as attending for use as ed by the a Records, P.O. þ leted Division of Vital ို Certification: I or Attending Fafter death. After the Director:

Physician /Medical

Physician

/Medical

Examiner

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Be Completed

Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any nigury or other traumatic event, the Medical Examin at must be rediffed at once.

within 24 hours a To the Funeral C the Hospital

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Physica

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) suite trel

32. Registrar's Signature

5 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#2,3 per PHY. State of Maryland Department of Health and Mental Hygiene State Registrar 4/9/08 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 2. Date of Death 4/5/08 1. Decedent's Name (First, Middle, Last) 3. Time of Death ROTTO FRANCES **Physician** /Medical 2214 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis 1044 Pine Crest Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/7/1920 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Sex 1 M 2 E **Funeral** Months Days Hours Illinois 299-42-0147 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 ☐ Yes 2 No Anne Arundel Annapolis Maryland| 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 1044 Pine Crest Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ White 3 X Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Mary Fogerty Clarence Stein ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1219 Eden Lane, Annapolis, Maryland 21403 Laura K. Riddle/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 4/7/08 Kalas Crematory Edgewater, MD 5 Other (Specify) al Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signaty 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that chured the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examine burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Home 1 □ Yes 2 1 2 No Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? o the Hospital or Attending Pl ithin 24 hours after death. o the Funeral Director: After the ompletely filled in by the funeral 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death cerificate be executed Division or Vital Physician:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Show

23a or 28a-f

or items

natural

other

State Registrar

Medical

29a. Certifier

th, Day, Year)
APR 0 31. Date filed (Month 9 2008 32. Pagistrar's Signature

445

who completed cause of death (Item 23a) (Type Print)

VEFENSE

29c. License number

29d/Date signed (Month, Day, Year)

this

After

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death

The law requires that the death certificate be executed attending physician and for use as the burial-trae Division or Vital Records, P.O. Box 68760, signed by the aid be detached f has e 2 funeral

For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Harry Gregory Kosky 05, 2008 4:40 A M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park 1 Emerson Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 87 217-18-9712 Director Aug. 17,1920 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-- any injury or other traumatic events. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Anne Arundel Severna Park MD 1 ☐ Yes 2 🙀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 1 Emerson Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1942 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Officer Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Wolanis Teodor Kosky မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Emerson Road Severna Park, MD 21146 Marcie Stephenson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition April 10, 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, Maryland 2008 21. Signature of Funeral Service Ltc 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HUPERTENSION HYPERLIPIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an certificate has rector, page 2 autopsy performed' To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 Yes 2 No ieral Director; A 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I wan a wooh in D24768 4-7-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM A DABBS, In. 21012 PENINSHLA Rd, ARNOLD, MD FARM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 0 2008

	1-	For State Registrar				Marylar	Cer	tificate	e of L				Reg. No	en de	100	100
	1.	Decedent's Nam	e (First, Middl	e, Last)								2. Date of Do	eath Da	V.	Year	3. Time of De
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by F		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Year or Dates:				e		I □ Yes	2 X No	Specify:				Specify	v: Wh	ite
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Be	17	17. Father's Name (First, Middle, Last) Austin Hudson										e (First, Middle Kinken			ne)	
To	11	9a. informant's N	lame/Relations	ship (Ty)	pe. Print)		19b. Mailir	g Address	(Street	and Numbe	er or Run	al Route Num	ber, City	or Town,	State, 2	Zip Code)
		George J	J. Klug	/ hu	usband		647	Breto	on P	lace	Arn	old, M	D 210	012		
	20	0a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation		Removal from	State	Place of Dispo cemetery, crer	natory or o	other plac	:e)		I 08,				Town, State , Marylar
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State Registrar 31. Date filed (Month, Day, Year)
APR 1 0 2008

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9879 5-2-08 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 710PM PATING 2008 IPR 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner RINDEL -UTU RECARE NOLL HERMPOAKE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/2/1917 9. Birthplace (State or Foreign If Under 1 Social Security Number 6. Sex MASS **Funeral** Months Days Hours M 2□F 90 Director 014-07-2003 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show items 23a or 28a-f shov ner must be notified at Annapolis 1 ☐ Yes 2 ☑ No Anne Arundel MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21409 570 Bellerive Rd. by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ral", or item Examiner tottes?

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tott 1 ☐ Never Married ※X Married 1 ☐ Yes 2√☐ No White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced "natural", the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARA Vending Supervisor other 7 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maguire Catherine William Keating ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, MD 21409 570 Bellerive Rd. Wife Anna Lee Keating 27 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: if It
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/9/2008 Crownsville, MD 21401 Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 170 Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RDIAL INFARCTION Physician 1.40212 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Day to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □ hknown DOMONTIA POPIPHOPAL UNSCULAR DISCHE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Peath (Check only one) Hospital: Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident I Director: d in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D 1 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ens HIGHNAY MALLESTERSWELLEMBZILLS ress of person who completed 31. Date filed (Month. APR 1 0 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) MONT/14/2008 2:45 Margaret Kerbin а м 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Months 0471471915 ŰŠÄ 1 ☐ M 2 🛛 F 216-38-9692 93 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No MD Snow Hill Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 430 W. Market St. 21863 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Newspaper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charlie King Howard Catherine Merrill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte Cathell/Daughter 36 Pinehurst Rd., Ocean Pines, MD 21811 Date 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of 20a. Method of Disposition All Hallows Episcopal Churchyard 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/19/2008 Snow HIII, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 23a. Part 1. Ent. by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause of earthing. 108 William St. Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown . Were autopsy findings available prior to completion of cause of dealh? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 PER/OutpatienI 3 □ DOA 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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Physician /Medical

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permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "I amy fujury or other traumatic event, the Maganse.

Physician /Medical

Examiner

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29a. Certifier

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6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and little of certifie

SARAD R. BARAL 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number 54422

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29d. Date signed (Month, Day, Year)

4-14-2008

State Registrar

31. Date filed (Month, Day, Year) APR 1 4 2008 32. Agistrar's Signature

SARAC; 1604 - Market

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician APRIL 09, 8:45P.M Donald Herbert Keene 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours Min. Vrs Director 071-01-2002 90 20 1917 Dec. Minnesota Usual Residence of Decedent 10a. State 10c, City, Town or Location show 10b. County 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Maryland Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 14010 Maugansville Rd. Funeral 21767 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 D Yes 2 □ No If it es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cost Estimator Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Herbert Keene Louise Josephine McLaughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Peter Keene / Step-son 501 Raven Ct. Colleyville Texas 76034 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of 5 ☐ Other (Specify) 4 ☐ Donation Smithsburg Crematory 4/16/2008 Smithsburg Maryland of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Candis Vana Physician Arterio Sileratio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Unusrying Cause (Disease or injury Examiner Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the buria Completed by Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4⊡Pregnant at time of death 2 □ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ Iriknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Vursing Home 1 Yes 2 No ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this

filled in by the funeral di this 5 Residence 6 ☐Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year) **APR 15** 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





State

Registrar

D0018019

301-739-7100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Shirley A. Lombardo 2008 3:09 PM April 07, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) District of Columbia If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 577-40-9086 1 □ M 2 🕱 F 77 June 02,1930 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ine Medical Examinar must be notified at MD Oueen Anne's Chester 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21619 418 Cross Creek Court Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 No White Specify: ⋛ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F is marked ott Mary Maisak Walter Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur 418 Cross Creek Court Chester, MD 21619 James Joseph Lombardo/husband altimore, April 11, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland MD Veterans Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lense Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 P.A. Severna Park Funeral Home rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate / ause (Final **Physician** neumonia disease condition condition condition (/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) that initiated events Examiner Due to (or as a consequence of): death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending posterior that the ast IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 5 Other (specify) 0 ☐Yes 2 No 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to pleath but not resulting in the underlying cause given in Part I. Records, ģ renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 $\underline{\square}$ Residence 6 $\underline{\square}$ Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a πpletely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D24804 Cers MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ame Annopelis med 21401

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8, perFH, G883, 9/12/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Arthur LINDAN 8:50 P 9 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring 3142 Gracefield Rd. #604 8. Date of Birth (Month, Day, Ye 1921 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□F 86 080-16-8788 Director New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, tite Medical Examiner must be notified at any Injury or other traumatic event, tite Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 XNo Montgomery Silver Spring Director MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20904 U.S.A. 3142 Gracefield Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1.11.1 T 11. Marital Status 1 MYes 2 No WWII Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: Year or Date 15 3 X Widowed 4 ☐ Divorced Army Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting/ Law CPA/ Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Waller Samuel Lieberman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1985 Lancashire Dr., Potomac, MD 20854 Sharon Mayl / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Cedar Park Cemetery Apr.11,2008 Paramus, NJ 4 ☐ Donation 5 ☐ Otber (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cryse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure with Diastolic Dysfunction **Physician** /Medical Due to (or as a consequence of): Examiner Aortic Valve Replacement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Renal Failure Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 「Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 合計istory of Lung Cancer probable recurrence, chronic 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed obstructive pulmonary disease, anemia of chronic disease, ^24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1∐ Yes 2 No recurrent cellulitis 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 🔏 ☐ No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ၉ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 12 Natural 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. aleyson D 44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring 3110 Gracefield Rd Rachelle M 31. Date filed (Month, Day, Year) egistrar's Signature State 11 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔠 🗓 🖔 State
Registrar AMEND#23a(b-dPperMD 4-11-08, BMV, ModGertificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 7:45 a 2008 Shee Hing Lim April 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 16112 Llewellyn Manor Way Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) Months Days Hours Min. 1 □ M 2 😾 F 101 152-42-5608 Dec 21, 1906 China Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16112 Llewellyn Manor Way 20905 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Asian δ Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home and Mental Hygies marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta fitem 27 is marked rother traumatic ev You Sui Lim Kwan Hui Ng ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Samuel Peter Eng /Grandson 16112 Llewellyn Manor Way, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If in any Injury or once. 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Apr 12, 2008 Suitland, MD Ceme PayName and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Melkerich arke 500 University Blvd W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CARDIC PULWANACY ACCEST. /Medical Due to (or as a consequence of)

Dehydration Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Failure to Thrive The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Alzheimer Dementia attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should ! Completed e24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s autopsy performed certificate ial or Attending Physiclan: The safter death.
S affer death.
SI Director: Affer this certificate ed in by the funeral director, pag 2 XNo 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the beet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050207 08 2008

State

Registrar

31. Date filed (Month, Day,

APR

ISOZ SOUTH MAEN ST

MT. ALRY

MD. 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL ENG. M.D.

2008

egistrar's Signature

Kenneth A. Lombardi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and prietly filled in by the funeral director, page 2 should be detached for use as the burial - transing transities in the funeral director, page 2 should be detached for use as the burial - transities in the funeral director, page 2 should be detached for use as the burial - transities in the funeral director, page 2 should be detached for use as the burial - transities in the funeral director, page 2 should be detached for use as the burial - transities in the funeral director in the funeral	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	patient	3 DOA	Other:	Nursing	Home 5	Res	idence 6	Other	: Scene	
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		30. Name and address of person	n who completed ca	ause of death (It	em 23a)										
3H			Assistant Medic			Penn	Street, Balt	imore, N	/ID 2120	01					
	ate		1. 32.	Registrar's Sign											
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Elizabeth C Loperfido April 21 2008 A^{M} 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country)
 TT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9-14-1921 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 86 100-12-1627 NY Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? **USA** Funeral 6512 Springwater Ct Apt4203 Fred., 21701 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ģ 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Item 27 is marked other other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiny or other traumatic event once. Be Joseph Reilly Elizabeth Roepke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Migdal Son 6512 Springwater Ct Apt4203 Frederick MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crem. 4 ☐ Donation 5 ☐ Other (Specify) 4-22-2008 Smithsburg, MD 22. Name and Address of FacilityKeeney & Basford P.A. F.H. Signature of Fungral Service Licens M01176 106 East Church St. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immedia e Cause (Final disea e or condition sulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the s detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/1/0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes ۲ 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Whatural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) deriuna MD 065443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Elena Iarikova 400 West 7th Street Frederick, MD 121701 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State APR 2 5 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 8, Day 2008 **Physician** 2:20 P M Bernard M. Levin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6809 Breezewood Terrace Rockville Montgomery f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 187 M 2 □ F Yrs 071-24-7983 78 17, 1930 New York Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural": or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1KYes 2 No Director Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6809 Breezewood Terrace 20852 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Research Psychologist U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Abraham Levin Mabel Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley U. Levin - Wife 6809 Breezewood Terrace Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ⊠Removal from State King David Mem. Gdns. 4/11/2008 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service License Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer of the Bladder disease or condition resulting in death) year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Cancer of the Prostate Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) 1 X Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifiel Medical

To the

State Registrar

Alan R. Weinstock, MD 31. Date filed (Month, Day, Year) 11 2008 APR

Www.5fork

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D09748

29c. License number

29d. Date signed (Month. Dav. Year)

April 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** LILLER 10 2008 SHIRLEY Ann 04 1400 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 ■ M 2 F 215-56-8618 22 1935 **Director** Nov Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show must be notified at WV Mineral Piedmont 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 514 W Piedmont St 26750 items 23a United States permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event the Medical Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen (Teets) Mayhew Larry Mayhew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21562 19a. Informant's Name/Relationship (Type. Print) Milburn Ziler/Son 21406 New Georges Creek Rd., Westernport, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bloomington 4/14/08 Bloomington, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home, 111 Church St, Westernport, Md 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma 4 Month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1☐ Yes 21 No 1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 17 Inpatient 3□ DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1-Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifies (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kept Avenue Cumberland, MD 21502

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

14

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 705pm 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4/5/2008 James F. McCusker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Dav. Year) **Funeral** Hours Days Min. XXM 2□F 89 039-03-8287 3/16/1919 ŔΙ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatte excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 933 Edgewood RD. 117 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 Types 2 □ No 41 —
If Yes, Give
Year or Dates: 45 1 ☐ Never Married 🏋 Married White 1 ☐ Yes 2 🛣 No Specify. Specify: þ 3 Widowed 4 Divorced 45 Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bridge & Tunnel Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard McCusker Helena Kelley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Edgewood Rd. 117 Annapolis, MD <u>Lucy McCus</u>ker Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4/7/2008 Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servi Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) he law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cale has t autopsy performed? 1 Yes 2 death? 1 ∐ Yes certificale 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 Pending Injury within 24 hours after account to the Funeral Director; Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

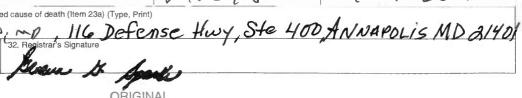
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

STEDITON GORIMON 31. Date filed (Month, Day, APR 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0755 A M 2000 Grover Cleve Merritt /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 2 Hrs.
Months | Days | Hours | Min. Hospita 8. Date of Birth (Month, Day, Year)
Sept. 27, 1931 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number **Funeral** 231-36-7568 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 10a. State 10h County Dorchester Yes 2 □ No Cambridge MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21613 USA 23a 301 Henry St. Apt. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or ite 1▼ Yes 2 No If Yes, Give Year or Dates: 1 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: white þ 3 ☐ Widowed 4 € Divorced 1949-53 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction electrician unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Albert Merritt Flora Moore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Wyman Dr., Salisbury, MD Sheryl Suiter daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/15/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstrictive Pulmonary Utscase Immediate Cause (Final disease or condition resulting in death) hrowic **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MATION 1 Yes 2 No 3 Probably 4 Unknown Completed Procumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes '2 ☑ No 1 pnpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatr To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tracertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Baltimore, Maryland 21215-0036

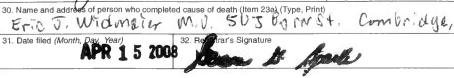
Records, P.O. Box 68760,

Division or Vital

State Registrar 31. Date filed (Month,

Eric J. Widmain

29b. Signature and title of certifier



29c. License number

DOO 61822

29d. Date signed (Month, Day, Year)

MD

04/14/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 8102AM 04 08 ROBERT Mc ALEENAN 4a. Facility Name (If not institution, give street and number) Marigot Beach Condominium 10002 Coastal Hwy. Suite 90 5. Social Security Number 6. Sex 7. Ac 4c. County of Death 4b. City, Town, or Location of Death Ocean City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 02/23/1950 9. Birthplace (State or Foreign Country) (In yrs. last birthday) Age (**58** 140-42-2884 XXM 2□ F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No 0cean New Jersey Barnegat 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Shelli Terrace 08005 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 1 No 1 🗌 Yes Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Regional Sales Manager Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James V. McAleenan Elizabeth Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite E. McAleenan/Wife 5 Shelli Terrace, Barnegat, NJ 08005 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 4/17/2008 |Manahawkin, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 Williams St. Berlin, MD 21811 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCHEDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ILEACT ATTACK 2□ No 101 1001-3 ☐ Probably

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trai as the l attending properties of the second se detached should be

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical ģ Be Completed page 2 s completely filled in by the funeral director, Certification: To

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after death.

within 24 hours a

TELINI MI	TILK TIV TY	70-3		16.00 2					
				24a. Was an autopsy performed? 1∐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ◯ No				
25. Was case referred to medical		26. Place of Death (Check only one)							
examiner? 1 MYes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing F	Home 5 ☐ Residence 6	Other (Specify)				
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death occurrenation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)				

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) 4

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

203 SNOW ST. SNOW HILL, ND. 21863

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 9, 2008 1:35 P M Hildegard McNamee 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick County Vindobona Nursing Home Braddock Heights 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 1937 Mannheim, Germany Hours 1 □ M 2 🗓 F 217-58-4099 70 14 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2X No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 12304 Richwood Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 24 Married 1 □ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Karl Kremer Helena Kreiger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Graham Harrison McNamee-husband 12304 Richwood Dr Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial
Park 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4-12-2008 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chrice Immediate Cause (Final disease or condition resulting in death) to MONTHS Due to (or as a consequence of): YEARS Dementin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Exprinter mass 1.

/Medical

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e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Furneral Director: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

within 2.

of death 5 Other (specify)		Month Day Year
resulting in the underlying cause given in Part I.		se contribute to the cause of death?
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2ຝNo
26. Place of De	ath (Check only one)	
2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 6	3 ☐ Other (Specify)
28b. Time of 28c. Injury at	28d. Describe how injury	/ occurred
At home, farm, street, factory, office pecify)	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
knowledge, death occurred at the time, date and place mination and/or investigation, in my opinion, death occ	ce, and due to the cause(s)	and manner as stated. place, and due to the cause(s)
29c. License number D006222		e signed (Month, Day, Year)
-	2 ER/Outpatient 3 DOA Other: 4 Nursing ar) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No At home, farm, street, factory, office y knowledge, death occurred at the time, date and place mination and/or investigation, in my opinion, death occurred at the time.	24a. Was an autopsy performed? 25. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Place of Death (Check only one) 28b. Time of Injury Mork? 1 Yes 2 No 28d. Describe how injury at Work? 1 Yes 2 No 28d. Describe how injury at City or Town, State) 28d. Marsing Home 28d. Describe how injury at City or Town, State) 28d. Location (Street and City or Town, State) 28d. Nowledge, death occurred at the time, date and place, and due to the cause(s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) mination and/or investigation.

WH-3 State

31. Date filed (Month, Day, Year) APR 15



Registrar

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		For State Registrar 1. Decedent's Name (First, Middle, I	Last)	Ce	rtificate of Death	2. Date of Death	J. No. 2008	3. Time of Death		
Physici /Medi		CHARLOTTE GAR	NER MILLS			APril	1 2008	10:10 AM		
Examir	w	4a. Facility Name (If not institution, g	`	aston	4b. City, Town, or Location of Deat Easton	th	4c. County of Death Talbot			
Funeral		.0	. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs					
Director		213-22-9749 Usual Residence of Decedent	1□M 2 X F	80 Yrs.	Months Days Hours Min.	oCT 9,19	th (2017) 9. Birthplace (State or Foreign Country) NORTH CAROLINA			
yland now at		10a. State 10b. County		10c. City, Town or Lo			10d. Inside City Limits			
ne Mar 8a-f sl otiffed	Funeral Director		LBOT	EASTO		140	1 X es 2 No			
with the a or 2 to be no	Dire	10e. Street and Number 610 DUTCHMANS I.	ANTE		10f. Zip Code 21601	100	10g. Citizen of What Country?			
death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - America Black, White, e	n Indian,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2X No Specify:	Tio Tiodii, 6tc.)	Specify: WHI			
2 hour atural	ted b	15. Decedent's	Education	16a. Dece	dent's Usual Occupation	10	6b. Kind of Business/Ind			
ithin 7, ne. Medi	Completed	(Specify only highest : Elementary/Secondary (0-12)	College (1-4or 5+	-)	kind of work done during most of wo DO NOT use retired)	orking				
iled w Hygier ther th nt, the		12 17. Father's Name (<i>First, Middle, La</i>	0	НС	DMEMAKER 18. Mother's Na	me (First, Middle, Ma	OWN HOME			
lid be f lental l ked ol ic eve	To Be	GEORGE G. GARNE	•		INEZ	, , , , , , , , , , , , , , , , , , , ,				
2 shou and N Is mar aumat		19a. Informant's Name/Relationship			ng Address (Street and Number or F			Code)		
1 and Health Sm 27 ther tr		VAN E. MILLS/SO 20a. Method of Disposition	ON	2930 20b. Place of Dispo	D3 PIN OAK WAY, E		21601 Oc. Location - City or Tox	vn State		
ages ent of I nt: If ite		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery, cre	matory or other place)		EASTON, MARY			
permit. F Departme Importan any injur		21. Signature of Funeral Service Lie			2. Name and Address of Facility FELLOWS, HELFENBE					
e a E e e		JOHN R	MERCE	RON 2	200 S. HARRISON S	T., EASTO	N, MD 21601			
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Physician /Medical		disease or condition resulting in death)	a.	consequence of):	MA OF UNKNO	6V14 /121	Juliey	<u>-</u>		
Examiner										
ed sit	Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):						
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To the Hospital or Attending Physician; The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome part of the last of	of pregnancy Fetal death 3 Fetal death 5 Fetal death 5 It not resulting in the unit 2 ER/Outpatie Year 28b. Time of Injury Property 28b. Time of Injury Property 18b. Time of Injury Property 28b. Time of Injury	26. Place of Dent 3 DOA Other: 4 Nursing of Work? M 28c. Injury at Work? M 1 Yes 2 No reet, factory, office th occurred at the time, date and place of the course of th	1 Yes 24a. Was an autopsy perform 1 Yes 2 Yes 2	Month acco use contribute to the second sec	e cause of death? e cause of death? ably 4 Unknown by findings available enpletion of cause of 2 INO Route Number, ated. the cause(s) Day, Year)		

DHMH 17 Rev 1/2001

Registrar 5 DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

Susan Bates, M.D.,

APR 25

ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

29c. License number

N.C.I., 10 Center Drive, Bethesda Maryland 20892

29d. Date signed (Month, Day, Year)

April 18, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Yea Oct 20, 1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours \$€ M 2 □ F Yrs. 1918 Maryland 89 Director 215 07 8010 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 □Yes 2NNo Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 United States 9906 Frederick Rd Funeral Items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No li Yes, Give Year or Dates: 1942-44 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than the M Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Baltimore City 7 Is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Carroll Melvin Mary Agnes McMahan ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Melvin/Son 2542 Melba Rd Ellicott City, MD 21042 Department of Health Important: If Item 27 any injury or other trong once. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 4-17-2008 Owings Mills, MD 21. Signature of Funeral Service Licensee M01044 Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl (F FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1□ Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) a No Hospital: 1 ☐ Yes 1 ___mpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Iniury after death. Director: A 1 ☐ Yes 2 ☐ No 2 Acciden 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral C Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1241 State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

APR

14

2008

30. Name and address of

person who completed cause of death (Item 33a) (Type, Print)

Registrar's Signature

29c. License number

CARMEN

BS1851701

29d. Date signed (Month, Day, Year)

2008

		for State State Registrar	of Maryland / Dep <i>Ce</i>	ertificate of D			iene eg. No. 🤈 🦳	9	1362	
Physic	0,2	1. Decedent's Name (First, Middle, Last)				2. Date of Deat 04/13/	_	Year	3. Time of Death	
/Medi		Joseph W. Miller				04/ 13/	2008	f Darab	3:30 a M	
Exami	ner	4a. Facility Name (If not institution, give street and 784 Kings Run Road	number)	4b. City, Town, or l			4c. County o			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthpla	ce (State or Foreign	
Director		218-60-1176 ¹ X ^{M 2}	F 56 Yrs.	Months Days	Hours Min.	(Month, Day, 6/26/19		Couintry Mary1		
pu >		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation				100	I. Inside City Limits	
laryla shov	ŏ	MD Garrett						1 ☐ Yes 2 ☐ No		
the N 28a-1 notifii	Director	10e. Street and Number		Dakland 10f. Zip Code		1	0g. Citizen of W	Citizen of What Country?		
n with	iO le	784 Kings Run Road		2155	50		U.S.A			
III (Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 13. If Forces? es 2 1 No , Give , Give , or Dates:	. Was Decedent of His If Yes, specify Cubar X 1 ☐ Yes 2 ☐ No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- Americar , White, et Whit	c.	
thin 72 hours af e. an "natural", or Medical Exam	Completed I	15. Decedent's Education (Specify only highest grade complet	16a. Dec	edent's Usual Occupa re kind of work done do DO NOT use retired)	tion uring most of work	ing	16b. Kind of Bus	siness/Indu	stry	
led wi lygien her th	ပ်	12	Ma	aintenanman 	18. Mother's Name	/First Middle I	Ski Re			
be od o	Be	17. Father's Name (First, Middle, Last) Claude Allen Mil	ller	ļ		•	Roy	7)		
d 2 should be the and Menta is marked traumatic every	2	19a. Informant's Name/Relationship (Type. Print)		ling Address (Street a				State, Zip C	Code)	
and 2 sho ealth and n 27 is m		Debora K. Miller / wi	lfe 784	Kings Ru	ın Road,	0akla	nd MD	2155	0	
partition of your permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troones.		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	Omega	ematory or other place a Crematory	y 4/17,	/2008	20c. Location - 0 Morganto	own, I		
permit. Departr Importa any Inji		21. Signature of Funeral Strateg Liberises	000 C	22. Name and Address	Second	Street.	0ak1aı	nd, M	D 21550	
Physician /Medical Examiner		resulting in death) Due	all cell lung eto (or as a consequence of):						Approximate niterval Between Onset and Death Years	
certificate be executed ding physician and se as the burial-transit	/Medical Examiner	resulting in death) Last C. Due d	e to (or as a consequence of):				23d Date	e of deliver	v	
The law requires that the death certificate has been signed by the attending to be a should be detached for use as	Physician/M	in the past 12 months?	ive birth 2 Fetal death 3	B Ectopic pregnancy i Other (specify)			Mor		Day Year	
he law requires that he has been signed b tge 2 should be deta	by	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause give	n in Part I.	23e. Did to			e cause of death? bly 4 □Unknown	
	Completed						sy p med? d 2 No 1	rior to com leath?	sy findings available pletion of cause of ≧□ No	
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpati	ont 3000 Othe	26. Place of Deal			(C-aai6)		
ding After fune	tion: To	27. Manner of Death 28a. I	Date of Injury Month, Day Year) 28b. Time Injury	of 28c. Injury		ome 5 Resid 28d. Describe h	<u></u>			
ral or Atterdays after death	Certification:	3 Suicide 6 Could not be determined 28e. F	Place of injury - At home, farm, soulding, etc. (Specify)	street, factory, office			tion (Street and Number or Rural Route Number, or Town, State)			
To the Hospital or within 24 hours are To the Funeral Dit completely filled in	Medical ((Check only 2 Medical Examiner: On to	o the best of my knowledge, de he basis of examination and/or manner stated.	investigation, in my o	pinion, death occu	rred at the time, o	date and place, a	and due to	the cause(s)	
Voith Com	Σ	29b. Signature and the of certifier		29c. License	number		29d. Date signed	·	vay, Year)	
					023979		04/15/20	800		
	160	30. Name and address of person who completed Robert A. Goralski, M.		e, Print) rth Street	Oakland	MD 21	550			
S	tate		32. Registrar's Signature	G.	Juktanu	, LIJ 61	JJ0			
Regis		APR 1 5 2008	American , Mr.	Social E						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Dep State of Maryland / Dep Amend Item 25 per dr/verb	artment of Health an	id Mental Hygier	ne Ne. O O O O	10000					
			Decedent's Name (First, Middle, Last)		2. Date of Death	- E U U O	3. Time of Death					
	Physicia		Shirley Crawford	Main		Day Year 20 08	5:55 A ^M					
V.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of E		4c. County of Death						
	Examini	eı	Frederick Memorial Hospital	Frederick		Frederick						
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24		9. Birth	place (State or Foreign ntry)					
	Director		218-30-8937	Months Days Hours	Min. (Month, Day, Yea		yland					
	Di ana		Usual Residence of Decedent									
	ırylar show		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2√☐ No					
	e Ma	cto	Maryland Frederick Freder				**					
	or 24	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?					
	ath w		6779 Sunnybrook Drive	21702		United St						
	tems	Funeral		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White						
36	s afte	by F	1 □ Never Married 2 M Married 1 □ Yes 2 M No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Wh	ite					
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	pe t		edent's Usual Occupation	16b.	Kind of Business/Ir	ndustry					
15	n 72 1 "na ledic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most o DO NOT use retired)			,					
12	with iene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own H	Ome					
ס	filed Hyg other ent, i	Be C	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maid		Omc					
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	Albert Luther Crawford	N	ettie Hauer							
ary	shou ind M mar	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ing Address (Street and Number	or Rural Route Number, Cit	y or Town, State, Zi	p Code)					
	1 and 2 Health a em 27 Is		Herbert D. Main / Husband 6	779 Sunnyborrk	Dr Frederi	ck. MD 21	702					
Jre,	tem of He ltem		20a. Method of Disposition 20b. Place of Disposition	779 Sunnyborrk position (Name of ematory or other place)	Date 20c.	Location - City or T	own, State					
E	Page nent c int: If		1 K I Burial 2 I I Gremation 3 I I Bernoval from State (vet Cemetery 4	/11/2008 Fr	ederick,	Maryland					
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signalus of Funeral Service Licensee	22. Name and Address of Facility	Stauffer Fu	neral Hom	e					
m	an la		Youther Staubber	1621 Opossumt	own Pike, Fr	ederick, 1	MD 21702					
1	#		23a Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ardiac or respiratory arrest,		Approximate Interval Between						
	Physician		Immediate Cause (Final disease or condition	OF THE L	IVER		Onset and Death					
d	/Medical	resulting in death) a. Due to (or as a consequence of):										
В	Examiner		Sequentially list conditions, b.									
	p #	ner	if any, leading to immediate Due to (or as a consequence of):									
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
Ö,	ate be executed thysician and the burial-transit	m	resulting in death) Last Due to (or as a consequence of):									
8760,	ate b	dical	d									
9	death certific e attending p id for use as	Med	IF FEMALE:									
Вох	ath c	Physician/Me		☐Ectopic pregnancy		23d. Date of deliver Month	very Day Year					
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)								
<u>α</u>	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?					
ds,	signe signe d be	i by			1 ☐ Yes	2 No 3 Pro	bably 4 Unknown					
ÿ	v requ	Completed			24a. Was an	24h Word aut	topey findings available					
ä	e la has	шb			autopsy performed	prior to o	topsy findings available ompletion of cause of					
a	ician: Th certificate rector, pag		OF Was are referred to made a		1□ Yes 2▼	No 1 ☐ Yes	2No					
or Vital Records,	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 Clark 197 Innertical Clark	Other	f Death (Check only one)	a 🗆 a	76.1					
o	Phy r this ral di	- L	1 Yes 2 No	sik 3 BOA 4 Nuis	ing Home 5 Residence 28d. Describe how in		erry)					
on	dIng h. : Afte fune	tion	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	,							
Division	Attending r death. ector: After by the funer	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s	treet, factory, office	28f. Location (Street		ral Route Number,					
ă	after after i Dire d in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Si	rare)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, de									
	he H in 24 he Fi plete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		roccurred at the time, date	and place, and due	to the cause(s)					
	To t To t	Σ	29b. Signature and little of certifier	29c. License number		Date signed (Month						
			- S/Whitho	D 00 479	121							
•	7		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	- Friends	r Hn	71701					
	,		SIBTE A. KAZMI, MD 814	TOLL HOUSE JO	, 100 ve.(11	L,						
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 1 2008	D 00 479 Toll House Au								
	negisti	œI .	LILLY T TOOO & CONTROL TO									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year EUGENE 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY DLNET CHENERAL MONTGOMER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Director 214-30-0215 74 Tan 2, 1934 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location 28a-f show r than "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12604 McAdoo Court 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist/Clerk Pharmacy/Hardware Store 17. Father's Name (First, Middle, Last) 18 Mother's Name /First Middle Maiden Surname: Be Burl Nettles Ada Atkinson Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 ment of Health a Tamara A. White / Executor 2621 Tabiona Circle, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buria 2 Cremation 3 Removal from State permit. Pege Department o Important: If eny injury or Clinton, MD Resurrection Cemetery Apr 14, 2008 hature of Fundral/Se 21. Sig 22. Name and Address of FacilityFrancis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, ND 20901 Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTILOBAR Physician PNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien and the burial-transit death certificate be executed Physician/Medical 38 IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) o. the detached signed by ٩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ a ENIA 3 Probably 4 ☐Unknown 217 No 1 T Yes Completed peen FIBRILLATI 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page certificate 2 🗌 No 1 🗌 Yes Division of Vital 2 🖫 No 1 TYAS 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 212 No 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 DNatural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D the Hospital pellil 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 701 D59418 AS GUZONMIM 6 50. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr, Olney, MD 20832 ADEWUNMI OLUYEMISI 31. Date filed (Month, Day, Year) 324Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mildred Louise NELSON 2008 April 12 12:40P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Reeders Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 91 July 12 1916 Director Maryland 220-18-2137 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 TYPYes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11 W. Baltimore Street 21740 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garment Manufacturer Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Henry Pitsnogle Bertha Tressler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darrell Nelson - Son 13608 Barnhart Road, Clear Spring, Maryland 21722 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 4/16/08 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Interes a do Kennty disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner repentinga Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and I for use as the burial-transit death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2□No af er death.

Director: After this certific

i by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 No 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death or Attending (Month, Day Year) Injury 1 / Netrital 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 4 ☐ Homicide completely filled in To the Hospital o within 24 hours af To the Funeral D 1 Grentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DH-4

State Registrar

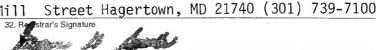
DHMH 17 Rev 1/2001

Dr. Vasant Datta 340 Mill APR 15 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

-att MD





D18015

ACRIL 13, 2008

MICHAEL A. NEWLIN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death-Month Day April 11, 2008 Michael **Bradley** NEWLIN Medical Examiner 0919 hrs 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 701 Pennsylvania Avenue Hagerstown Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min 218-96-2065 Months Days Hours Director Country)Maryland 1 X M 2 F 42 June 6,1965 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1 X Yes 2 No Hagerstown 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1023 Georgia Avenue 21740 U.S.A. **23**a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White If Yes, Give Yeer 3 Widowed 4 Divorced 1 Yes 2 X No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical Baltimore, MD 21215-0036 11 Λ auto body auto repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newlin Be Victor L. Linda Nichols ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Newlin - father 1023 Georgia Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) April 1 X Burial 2 Cremation 3 Removal from State 15, Hagerstown, Maryland Department Important: Rose Hill Cemetery 2008 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. /Medical Death a. Cirrhosis Immediate Cause (Final disease >> Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that is Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and sician/Medical physician the burial -UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as t Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (Specify) ned by the atter 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 Yes 28a. Date of Injury (Month, Day, Year After 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending hours after death. the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ٥ d manner stated. 29h. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 12, 2008 30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 WH-4 31. Date filed (Month) PR 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 363 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 6, 2008 02:50PM Edward Leo Oakes /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 78 Peppertree Circle North East If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. March 13,1948 Maryland 60 Director 218-44-0297 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland **BAltimore** Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21221 Bank Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White \$ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bridge 10 Construction permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Carper Calvin G. Oakes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 78 Peppertree Circle, North East, Maryland Lisa Rothblum / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mayerdale Crematory 1 ☐ Burial 2 【Cremation 3 | Removal from Stat Appil 2008 4 □ Donation Newark, Delaware 5 Other (Specify) 21. Signature of Fune al Service 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequer ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2**X** No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifie 2 Ö 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ö

State Registrar Gloria Simonson, M.D.,

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

111 West High Street, Suite 302, Elkton, Maryland 21921

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NORMAN RICHARD O'ROURKE М APR.17,2008 9:58A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLOTTE HALL VETS. HOME CHARLOTTE HALL ST. MARY' 9. Birthplace (State or Foreign Country)
PA 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** (Month, Day, Year) 10-20-1932 Months Days Hours 1**∑**M 2□F Yrs. 170-26-3036 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD. ST.MARY'S CHARLOTTE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 CHARLOTTE HALL RD. 20622 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Types 2 1 No NMY
If Yes, Give ARMY
Year or Dates 950-52 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALESMAN PEOPLES LIFE 12 ulth and Mental Hw 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 is marked of any Injury or other traumatic ew MARSHALL O'ROURKE LILA BECK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12916 JAMESON DR. WALDORF, MD. 20602 JEFFREY OKAZAKI-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State METROPOLITAN CREMATORY 4-23-08 ALEX., VA. 4 □ Donation 5 □ Other (Specify) M00479 22. Name and Address of Facility 21. Signature of Foneral Service Licenses RAYMOND FUNERAL SERVICE, P.A. Mechan LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Arlen Immediate Cause (Final 04 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions, if any leading to immodificate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed the burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à ARDIONE 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1☐ Yes or Attending Physician: Was cas a referred to medical examiner: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad impleted cause of death (Item 23a) (Type, Print) PRINCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 19, 2008 Year **Physician** Patricia Ann O'Connor 2:05 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Citizens Care and Rehabilitation Center Frederick Frederick 8. Date of Birth Dec. 13, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign **Funeral** 1 - M 200 219-20-0327 Maryland 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Frederick Frederick Maryland 1XXYes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21702 614 Schley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard E. McCaffrey Mary Elizabeth Engle ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Schley Avenue, Frederick, MD 21702 Richard J. O'Connor, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXXBurial 2 Cremation 3 Removal from State St. Johns Cemetery April 23, 2008 Frederick, MD 4 Donation 5 Dother (Specify) ²² Name and Address of Facility.
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21701 21. Signature of Funeral Service Liver see M00255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pranuctear **Physician** Due to or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) The law requires that the death certificate be executed Exami Due to (or as a consequence of): attending physician for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after deat 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a #Esertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09689 April 21, 2008 Darre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre, M.D., 300 West Ninth Street, Frederick, MD 21701

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State Registra

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04 Month **Physician** 20ď8 2235 CHARLES ONEAL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 26, 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min. 1 x M 2 □ F MD Director 220-10-7042 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Allegany MD Cumberland 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or the Medical Examiner must be 21502 USA 730 Furnace Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**o Maryland 21215-0036 Specify. Specify. ۵ white 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile laborer 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Coyle W. O'Neal Lucinda (McMullan) O'Neal ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 12043 Iris Avenue Cumberland William C'Neal brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4/21/2008 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun- al Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. ASPIRATION PNEUMONIA 10 DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes X☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 | No 1☐ Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√ No 2 ☐ ER/Outpatient 3 ☐ DOA P M Inpatient this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Low namo 30. Name and address of person who completed cause of death (Item 25a) (Type, Print) HOSPITAL , CUMBERLAND, MD OBUSTIANO REPAIMID 31. Date filed (Month, Day, Year) APR 2 5 2008 Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:47 PM **Physician** 2008 Grace Christina April Owens /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1□ M 2 🕇 F North Carolina 5/25/1921 Director 86 212-16-1942 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c City Town or Location 10a. State "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 Yes 2 □ No Director Salisbury |Maryland | Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21804 200 Civic Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: ģ White 3 Notice A □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Caroline Yates James Franklin Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1713 Emerson Ave. Salisbury, Maryland 21804 George Owens/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial 4/12/2008 Salisbury, Maryland 4 □ Donation 5 □ Other (Specify) Park 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd. Salisbury, Maryland 21804 21. Signature of Funeral Service Ligenses Kett 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) ALTHEIMERS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
ately filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Dhknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 2 1 No 200 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital within 24 hours a To the Funeral I

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 1 2008

Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804

State Registrar 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3637 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Dorothy F. Perkins April 2008 07:25 AM .0. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F 169-20-9408 89 Oct. 6, 1918 New Jersey Usual Residence of Decedent 10a. State New 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2□No Camden Barrington Jersey 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 504 DuBois Avenue 08007 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√€ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church Ministries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Horace Perkins Clara Merrill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David H. Perkins / Nephew 1701 Green Hills Drive, Nashville, Tennessee 37215 20b. Place of Disposition (Name of cemetery, crematory or other place)
Asbury Methodist
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April Cinnaminson, New Jersey 15, 2008 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1, Enter the disease, or comment ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ٧n

Physician /Medical Examiner The lew requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical

attending physician and signed by the at d be detached fo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition	Acute	Pyrm	PARAGO	Eden	9	Or	set and Death
resulting in death) Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	Regurgi	tation.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 □ Ectopic eath 5 □ Other (specify)			3d. Date of delivery Month Da	,
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I). 		se contribute to the c	,
					24a. Was an autopsy performed? 1 Yes 2 No	death?	findings availabetion of cause of
25. Was case referred to medical	5.		26. Place	e of Death (C	heck only one)		-
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OA Other: NI	ursina Home	5 ☐ Residence 6	□Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		28b. Time of Injury M	28c. Injury at Work?	28d	. Describe how injury		
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory)	ory, office	28f.	Location (Street and City or Town, State)		oute Number,
	hysician: To the best of my kno miner: On the basis of examina and manner stated.						
29b. Signature and title of certifier		2	9c. License number		29d. Date	e signed (Month, Day	, Year)
> roing 5. I	U/\		00058	354		alid 08	

State

Registrar

To the Hospital within 24 hours a To the Funeral L

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

MEGIN

APR 1 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20b, FH, TCHD, 04/07/08 pha Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Russell Edward Perkins 1:17A M 04 -03-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot 9380 Unionville Road Easton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 XM 2 ☐ F Maryland Director 84 217-14-8431 02-09-1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 1 ☐ Yes 2 ☐ No Funeral Director Talbot Easton Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23a or Iry or other traumatic event, the Medical Examiner must be Iry 9380 Unionville Road 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Thompson Motors Auto engine Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leinard Leonard Perkins Ethel Hemsley ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9380 Unionville Rd., Easton, Md. 21601 <u>Grace C. Perkins / Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriat 2 □ Cremation 3 □ Removal from State permit. Page Department of Important; If any Injury or Md. Vererans Cem 04-11-08 4 ☐ Donation | 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 426 Dover Street, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (Ancer 3 mm Thy Lung **Physician** /Medical Due to (or as a consequence of): Examiner MULTIPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atte in the past 12 months? 1☐Yes 2☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed?

1 Yes 2 ANo certificate Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2000 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1) Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month) Day, Year) | 32. Registrar's Signature | APR 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOB51132

Dr. Slite 104 EATON, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:30 PM HAZEL MARIE PERKINS April 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Talbot Easton 8. Date of Birth (Month, Day, Yea 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min. DEC 23,1916 220-48-0718 91 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notified 1 XYes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 545 CYNWOOD DRIVE 21601 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL JESTER BESSIE MAE TARBUTTON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN PERKINS ANDERS/DAUGHTER 31772 KINGSTON ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL PARK 4/8/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN MERCEROR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebrovascular accident Immediate Cause (Final **Physician** Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 [] Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifie

State Registrar

requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

To the Hospital or Attending Physician:

Hazel Perkins Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

UTCHMANS

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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#gistrar's Signature

08-02786 Jonathan Pritts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 13640

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(A.s.		4a. Facility Name (if not in	stitution, giv	e street and nu	ımber)	•	4	b. City, To		ocation of	Death			County of	Death	
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Funeral		Social Security Number	6. Se	ex	7. Age (In yr	s. last bir	thday)	If Under		If Under		8. Date of Bi	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign			
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Baltimore, MD 2121 Deemit Pages I and 2 should be fil Department of Health and Mental Important: If tiem 27 is marked injury or other traumatic event.		21. Sign have of Furreral	Service Do	see			22. N	ame and A	Address	of Facility	Stew	art F	unera	al Ho	me	01550
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Division pital or Attendion ours after death. reral Director: /	Certification:	3 Suicide 6 Homicide	Could no determin	t be		,				-	- 1	or Town	, State)			
lospir f hour uner		29a. Certifier	fyina Physi	cian: To the b	est of my kno	wledge, d	leath occu	rred at the	time, da	te and pla	ace, and	due to the ca	use(s) ar	nd manner	as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 12 Hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as s (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.									ue to th	e cause(s)					
To Vii	Me	29b. Signature and title of	of certifier	and manner	stated.			290	. Licens	e number			29d.	Date sign	ed (Mo	nth, Day, Year)
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		30. Name and address o	f person who	completed ca	use of death	(Item 23a)									
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9	tate	31. Date filed (Month, Da			Registrar's Si							-				
Regis		ADD.	1 4 20	18	William out	As	Anna	100 5								

		1	State of Maryland / Dep	artment of Health and N ertificate of Death		ene 3.No. 2008 1961.			
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year			
	Physicia /Medic		Ruth Joy Peters		April 10	, 2008 7:55 A M			
	Examin	er '	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
			Glade Valley Nursing & Rehab Center	Walkersville	15.0	Frederick			
	Funeral Director	,	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1) Aug. 7,	Year) 1925 9. Birthplace (State or Foreign Country) West Virginia			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or to	ocation		10d. Inside City Limits 1 ⊠ Yes 2 □ No			
136		ţ	Maryland Frederick Walker	sville					
		ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?			
		ral	56 W. Frederick Street	21793	N -	United States 14. Race - American Indian,			
		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	o Rican, etc.)	Black, White, etc. Specify: White			
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altimore,	Pages 1 annuary Pages 1 annuary or oth		1 ☐ Burial 2 Temation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthave	n Crematory 20	L 11, 08	rederick, Maryland			
Balt	permit. Departr Importa any inji		7//	22. Name and Address of Facility Resthaven Funeral 9501 Catoctin Mtn.	Hwy. Fre	ederick, MD 21701			
P.O. Box 68760,	rector, page 2 should be detached for use as the burial-transit.	dical Examiner	23 Part1. Enter the disease, or complications that caused the death. Do not a shock, or hear failure. List only one cause on each line. Immediate Cause if had disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	1		inferval Between Onset and Death			
		sician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
		by Phy	1 □ Yes 2 No 3 □ Probat						
Records,		Completed		perfori	autopsy prior to completion of cause of death?				
Vital	(0 0	Be C	25. Was case referred to medical examiner?	26, Place of De	ath (Check only on	ne)			
<u>r</u> <	<u>~</u> . <u></u> .	5	1 ☐ Yes No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpa		T	ence 6 Other (Specify)			
n or			27. Manner of Death 1X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Inju	y Work?	28d. Describe ho	ow injury occurred			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	27. Matilited of Death 1 Notatival 1 Notatival 2 Accident 3 Suicide 4 Homicide 4 Homi							
			29a. Certifier Check only Ch	eath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the courred at the time, or	cause(s) and manner as stated. date and place, and due to the cause(s)			
	thin 2 the mplei	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)			
	7 × 7 8		h h	D5164	3 A	pril 10, 2008			
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		mp 21212			
	6		Hirem N 5hap rp 65c	Thomas Thou	son Dy	Fredrock			
	Si Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrate Signature APR 1 1 2008	* Sporte		april 10, 2008 Predricks			

DHMH 17 Rev 1/2001

amended item # 17/4-11-08/k shd/map Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:20mm Year Month **Physician** ELIZABETH PRICE 04 05 2008 JULIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Eacility Name (If not institution, give street and number) Examiner Wicomico Salisbur Hospice at the oastal If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 □ M 2 T F Yrs 91 AUG.30,1916 DELAWARE 141-05-0962 Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10h County Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No DELAWARE SUSSEX SEAFORD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 123 NORTH PORTER STREET 19973 AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: Maryland 21215-0036 \$ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MAGISTRATE COURT College (1-4or 5+) Elementary/Secondary (0-12) CLERK Department of Health and Mental Hy, important: If Item 27 Is movement of Indian American In Indian American 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jackson Be ALBERT JACISON LANK ELIZABETH HAYMAN P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 SOUYH KAYWOOD DRIVE 19a. Informant's Name/Relationship (Type. Print) JOAN E. SIMPSON - DAUGHTER SALISBURY, MARYLAND 21804 Baltimore. 20b. Place of Disposition (Name of ODD) Place of Property Exemple (Name of Street Place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4/10/08 SEAFORD, DELAWARE 4 □ Donation 5 □ Other (Specify) CEMETERY 21. Signature of Fune al Service Lifensee WATSON YATES FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DELAWARE
enter the mode of dying, such as cardiac or respiratory arrest,

Approximate
Interval Between
Onset and Death , or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. e dise Parti En shock, or heart fail. Stroke Left Cerebul Sufant in ediate Cause (Fin or dise or condition resulting th) days **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed and burlal-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760. physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant et time of death 5 Other (specify) the detached 9□Unknown 9 Unknown ģ signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 1 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No N autopsy page performed? certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 StOther (Specify) 165 Pecce 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending ..enc. ..er death. ..ral Director: Affe. 'v filled in by thr Injury 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral Completely filled it Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D29505 3.9. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 1 1 2008

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR.

SALISBURY, MD 21801

		1	For State Registrar	State	of Marylan		artment rtificate			and Me		giene Reg. No.	2008	13643
			Decedent's Name (First, Middle	a, Last)						2	. Date of Dea	ath Day	Year	3. Time of Death
	Physici		Elmer Wallac	Revnol	ds					A	pril	-	2008	11:32 PM
de la la	/Medio Examir		4a. Facility Name (If not institution	, give street and	number)		4b. City, To	own, or	Location	of Death		4c. C	County of Death	
			Citizens Nurs	ing Home	2		Havre						arford	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under Hours	Min.	Date of Birt (Month, Da			place (State or Foreign intry)
	Director		221-12-4603	Xw 2U	84	Yrs.					uly 24	192	3 Mary	land
	within 72 hours after death with the Maryland ane. than "natural", or tema 23s or 28s-f show he Madical Examinar must be notified at	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
			Maryland Ceci	1	Not	rth Ea	st							XXYes 2 ☐ No
		Directo	10e. Street and Number				10f. Zip 0	ode	-			10g. Citiz	en of What Cor	untry?
	with	ក់	308 East Cecil	Avenue			219					Unit	ed Stat	es
	eath w	Funeral	11. Marital Status	12. Was I	Decedent Ever in U.	.S. 13.	Was Decede	nt of Hi	spanic Or	igin? (Spec	ify Yes or No ican, etc.)	- 1-	4. Race - Amer	
10	riter d		1 Never Married 2 Mar	ied 1 🖫 Y	d Forces? 'es 2□No Art	m7.7					can, etc.)	İ	Black, White	
38	urs af	è	3 Widowed 4 □ Divorced	i if YAs	or Dates: 1943		1 ☐ Yes 2	XNo	Specify:			·	Specify: Wh	Lte
Maryland 21215-0036	2 ho	Completed	15. Deceder (Specify only highe	t's Education		16a Dece	dent's Usual	Occupa done d	ition u <i>rina m</i> os	t of working	7	16b. Kin	d of Business/I	ndustry
	hin 7	를	Elementary/Secondary (0-12)	1	ge (1-4or 5+)		kind of work)			Manu	factur	ino
2	or th	5	12			ware	housen	lall	40 14-4	- d- Nome	First, Middle,			6
nd	d offi	Be	17. Father's Name (First, Middle, James Duffy Re								n C. Fe			
yla	and 2 should be filed within iself end Mental Hygiene. n 27 is marked other than "artraumatic avent, the Market	၉						(0)						in Code)
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	ges 1 and 2 nt of Heelth if item 27 is or other tre	1 1	Edward E. Reyn	olds /	Son 20h F	208 Place of Disp			-	Da			ation - City or	
9	Des 1 Fita or ot		20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 ☐Removal f	_ 0	th Eas	matory or oth	ier placi	CT	April				
Ē	Pac men tant: jury		`4 □Donation 5 □ Other (5		f`Ce	metery			i	12, 2				, Maryland
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Puneral Service	Licensee							ach Fu			1 and 21001
_	40 F 4 0		John										ist, Ma	ryland21901 Approximate
	Physician		23a Part1. Enter the disease, of shock, or heart failure. Lis	r complications to only one cause	on each line.	in. Do not en	rei rue mode	or dynn	y, such as	Cardiacoi	163phatory a	11031,		Interval Between Onset and Death
		8 0	disease of conduitor									Hours		
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):										45
	LAAIHIIICI	L	Sequentially list conditions, if any, leading to immediate		ORUNANT e to for as a conseq		ELY	Dist	-45E					YEARS
	pe 15	2	if any, leading to immediate cause. Either Undertying Cause (Disease or injury that initiated events Cerebro vascular Accident								Weeks			
	end end -tran	Examiner	that initiated events resulting in death) Last		e to (or as a conseq		5 M	دد ۱۷	スペレコ					0000.()
8760,	ete be executed hysiclen end the buriel-transl				TYPEKTEN	•								YEARS
87	physi the	e de		d	IIIPRIE							127	Ti.	
9 X	ding l	by Physician/Medical	IF FEMALE:	23c. If ves	s, outcome of pregna	ancy						2	3d. Date of del	ivery
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	101	ive birth 2 Feta	al death 3	□Ectopic pre						Month	Day Year
P.O.	Attending Physician: The law requires that the death certificete be executed rideeth. ector: After this certificete has been signed by the ettending physician end by the funeral director, page 2 should be detached for use as the buriel-transit	yslo	1 Yes 2 No 9 Unknown											
σ.		H.	Part II. Other significant condit	ons contributing	to death but not res	sulting in the	underlying ca	use giv	en in Part	1.	23e. Did tobacco use contribute to the cause of death?			
g,		5									1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uni			
ő		Completed									24a. Was	an	24b. Were au	topsy findings available completion of cause of
3e	has pe 2	E G										ormed?	death?	
a	ician: Th certificete rector, pag								ac Diag	a of Death	1 Yes	2 No	1 Tes	2 2 No
Ž	siciae certil recto	Be	25. Was case referred to medic examiner?	Hospital:	1 Dispetion 2 D	TED/Outpotis	at 3(100	_ Oth					S □Other (Spe	cifv)
ō	Phys rthis raldi	5	27 Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at						-	28d. Describe how injury occurred				
no	ding F h. After funer	Certification;	1 Natural 5 Pend 2 Accident inves	ing tigation	M 1 7 Van 2 7 No]No					
S	deel ctor: y the	flea	3 Suicide 6 Could	not be	Place of Injury - At h	jome, farm, s	treet, factory	office		2	8f. Location	(Street and	d Number or R	ural Route Number,
Division of Vital Records,	or letter Dire	ert	4 Homicide	building, etc. (Specify) City or Town, S						iwn, State,	State)			
	spita ours nerai		29a. Certifier 1 Certify	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									s stated.	
	To the Hospital or Attending Physician: The within 24 hours elter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medica one)	l Examiner: On and	the basis of examina manner stated.	ation and/or i	nvestigation,	in my o	pinion, de	ath occurre	a at the time			
	To the vithin To the complex c	Me	29b. Signature and title of certif						e number				e signed (Mon	
	- > - 0		1 4	40			1	000	477	11		Apr	-11 10,	2008
	MUNITER	1	30. Name and address of perso	n who completed	cause of death (Ite	m 23a) (Type	e, Print)							
	1011		DAVID GAL-EL	304-3	306 North	str.	et 5	uite	*3	ELK	TON 1	イネイイ	LAND	d1921
	S	ate	31. Date filed (Month, Day, Yea	1 2000	32. Registrar's Sign	ature	breek	,						
9	Regis	rar	APR 1	1 2008	Elever	10	!							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:30 P Arthur Gunby Reese April 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis HealthCare - The Pines Talbot <u>Easton</u> 8. Date of Birth (Month, Day, Year, 06–20–1911 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 96 Director 214-32-6897 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Funeral Director Md Talbot St. Michaels 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 8391 Grace Street, extended 21663 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Maryland 21215-0036 Specify. Completed by 3 N Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years <u>Automotive Repair</u> Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Reese Florence Causey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucretia Krantz (daughter) P.O. Box 42, St. Michaels, Md. 21663 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Capitol Crematory 04-06-2008 Dover, De 4 Donation 5 Other (Specify) 22. Name and Address of Facility Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licensee P.O. Box 518. St. Michaels, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each fine. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia

Due to (or as a consequence of): years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissass or lighty that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sundrome of in morning and disturbed with a surface of the commone 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? /es 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4XXNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) 10 Michael Crowley, MD 610 Dutchman's Lane, Easton, Md 21601 31. Date filed (Month, Day, Year) State APR 0 7 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician William Newman Richards 9:15 P M 10, 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Date of Birth (Month, Day, **Funeral** Months Days Hours 1 XM 2 □ F 30, Director 200-22-3035 78 1930 Pennsylvania Mar Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No MD Montgomery Wheaton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportant: If Item 271s marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Eventure. 20902 USA 12517 Arbor View Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1954-56 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing/Direct Mail Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Newman Richards, Sr. Ruth Bartholomew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie S. Richards/wife 12517 Arbor View Terrace Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory: 04/14/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Lung Cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 X No Other: $4 \square$ Nursing Home $5 \square$ Residence 6×10^{-1} Other (Specify) hospice 2 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital of within 24 hours at To the Funeral D 1541

29b. Signature and title of certifier

D64615

29c. License number

1 🕇 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

April 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Génevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) APR 14 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year April 9, 2008 1:30 A^M Jon Edward Rosenberger, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany Cumberland 13702 Oleander Dr. | If Under 14 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 12, 1937 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 ★ 2 F 220-34-1489 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2X No Cumberland Allegany 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 13702 Oleander Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 XNo 1 Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Raymond Rosenberger Pearl Beachy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13702 Oleander Dr., Cumberland, MD 21502 Mary E. Rosenberger/Wife 20c. Location - City or Town, State 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Grantsville Cemetery April 11, 2008 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, 21. Signature of Fundral Service | nsee Cuma P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End5 ZYRS Due to (or as a sequence of): Sequentially list conditions, and the sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 2 No

Pnysician /Medical Examiner

attending physician and for use as the burial-transit

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certificate

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Director: After

death.

after

within 24 hours a To the Funeral E

filled in by the luneral

or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Funeral Director

þ

Completed

Be

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is markad other than "natural", or Itama 23a or 28a-f show any injury or other traumatic svant, the Modical Examinar must be notified at 900s.

Baltimore, Maryland 21215-0036

Examiner an/Medical 0 Physic þ Completed Be 은 Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

24a. Was an

1 Yes 2 12 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home

5 Pesidence 6 Other (Specify)

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

5 Pending

investigation

Could not be determined

25. Was case referred to or dical examiner?

31. Date filed (Month, Day, Year)

1 🗌 Yes

27. Mann Death

1 ENatural

2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

21502 M.D., 925 Bishop Walsh Rd. Ste. 4, Cumberland, MD Dr. Gary L. Wagoner,

State Registrar

Medical

32. Registrar's Signature

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19 2008 Year APRIL PHILLIP RUBIN 9:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | Apr. 21, Year 1945 | California 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 151-34-3391 1 X M 2 □ F 62 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Frederick 1 ☐ Yes 2 No Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9009 Mountainberry Court 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Medical Doctor Health Care tem 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental Important: If Item 27 Is marked or any Injury or other traumatic eve Robert Louis Rubin Doris Levy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 9009 Mountainberry Court, Frederick, MD 21702 19a. Informant's Name/Relationship (Type. Print)
Mrs. Angelika K. Rubin, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Smithsburg Crematory Apr. 21, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Reener of Basford PA Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bocterunia **Physician** Enterococcus disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Foilur Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or se a consequence of) death certificate be executed Sepsi's burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 Z No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4/20/08 00063157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATELMO HITOSM 915 Sulter FREDERICK MD Toll *3*07

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

State

Registrar

Year)

2008

2(70)

32. Regutrar's Signature

			For	State of Mar		partment of Fertificate of			giene [Reg. No.	08	13648
			Registrar 1. Decedent's Name (First, Middle	, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia		James	н.		Snyder		Month April	6,2008	Year	10:45 PM
	/Medic Examin		4a. Facility Name (If not institution	give street and number)			r Location of Deat			nty of Death	
			527 Queen Anne			Odenton	T MILL IN OATH			Arun	
	Funeral Director		5. Social Security Number 218–24–8218	6. Sex 7. Age (In yrs. last birthd 78 Yrs	Months Dave	Hours Min.		71930		place (State or Foreign ntry) ryland
	land ow it		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town o	r Location				1	10d. Inside City Limits
	Mary a-f she	tor	MD Anne	Arunde1	Ode	enton					1 ☐ Yes 2 😿 No
	with the 3a or 28s	Il Direc	10e. Street and Number 527 Queen Anne	Ave.		10f. Zip Code 21	113		10g. Citizen o	of What Coul US	•
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2CXMarri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1XXYes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	I3. Was Decedent of I If Yes, specify Cub		Specify Yes or No rto Rican, etc.)	Spe	lace - Americ lack, White, cify:	
2-003g	72 hor natura dical E	eted	15. Decedent (Specify only highes	's Education It grade completed)	16a. De	ecedent's Usual Occu five kind of work done fe. DO NOT use retire	pation during most of wo	orking	16b. Kind of	Business/In	dustry
7	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		re. DO NOT use retire Fechnician	a)		West	inghou	se
0	illed Hygi other rent, t	Be Co	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	. Maiden Surn	ame)	
/land	ould be Menta arked attc ev	To B	Frank Snyder				Agnes				
Mar	nd 2 sho alth and 27 Is ma r traum		19a. Informant's Name/Relationsh Irene Snyder	nip (Type. Print) Wife		ailing Address (Street Queen Ann		Rural Route Numb Odenton,			o Code)
saitimore,	ages 1 and of the first th		20a. Method of Disposition 1		cemetery,	isposition (Name of crematory or other pla d Veterans		Date 0 / 2008	20c. Locatio		
	nit. Pa artmel ortant injury		4 □ Donation 5 □ Other (S		rial y lain	22. Name and Addr		0,2000		dgely	
ñ	permi Depar Impor any ir once,		17 90			Hardesty	Funeral 1	Home P.A		_	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Myoc		1 infar		ac or respiratory a	rrest,		Approximate Interval Between Onset and Death Sudden
i i	08,09	je.	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury	b	consequence of	Υ.				- 10	
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)						
8/60,	cate be executed physician and the burial-transit	dical E	g cca,	d.							
õ	rtificat ng ph) as th	Medi	IF FEMALE:								
C. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome por 1 Live birth 2 4 Pregnant at ti	☐ Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	су			Date of deliv Month	rery Day Year
, r.	w requires that the d been signed by the should be detached		Part II. Other significant condition	- ^	not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did t			the cause of death?
000	~ 970	eted	119561100	2101/				24a. Was			
Vital Records,	e lar has	Completed by						- auto	psy ormed? 2 No	death?	opsy findings available ompletion of cause of 2 No
ııa	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			100		eath (Check only	one)		
0	Physi this o	၉	1 ★Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		allent 3 DOA		Home 5 Resi			ify)
	ding Ph h. After th funeral	tion:	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, Day		ıry Wo	ork?]Yes 2□No	200. Describe	now injury oci	curred	
DIVISION	ul or Attending Physician: after death. Director: After this certification by the funeral director,	Certification:	3 Suicide 6 Could in determined	not be ined 28e. Place of injury building, etc.	y - At home, farm (Specify)	, street, factory, office		28f. Location (City or To	'Street and Nu wn, State)	ımber or Rui	ral Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical C		ng Physician: To the best of Examiner: On the basis of and manner state	examination and/						
)	To the within To the comp	Me	29b. Signature and title of certifie	Madarau	2 Mp	DM	03916	6	29d. Date sig	neil	7 2008
1	CH)		30. Name and address of person AWIN S. MA	DARANG	ath (Dem 23a) (T)	OR LANDI	MARK D	R. STE	128.G	lenBu	RNIE, MD
200	Sta Regist		31. Date filed (Month, Day, Year) APR 0	32. Pegistrar	's Signature	board .					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician P^{M} 2008 April 5:15 Margaret Kenney Smith 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 23 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2XX 579-12-4576 Maryland 87 1920 **Director** Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
Other than "natural" or items 23a or 200. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the "Notical Examinar must be notified at 1 □Yes 2√XNo Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21401 United States 2803 Berth Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√XNo Specify: Completed by Specify: White 3₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill f Health and Mental H item 27 is marked ott Be Lelia Mazella Parks မ Lester Lee Kenney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 104 Avondale Circle Severna Park, Maryland 21146 Donald Wayne Smith / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4/8/2008 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Kesouratou /Medical Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760, physician the attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Ö detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforr certificate 20 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner?

ONLY Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert ss of person who completed cause of itir (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) egistrar's Signature State APR 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1030 M JAMES SCOTT STARKEY 2068 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital @ Easton taston 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ▼M 2 □ F MARYLAND Director APRIL 14, 1929 218-24-4869 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director **MARYLAND** QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 359 KIDWELL AVENUE 21617 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1948—1952 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) CLERK/LETTER CARRIER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ EDGAR BENNETT STARKEY **EDITH ANDERSON** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra BARBARA BINEBRINK STARKEY/WIFE 359 KIDWELL AVENUE, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEMETERY CENTREVILLE, MARYLAND 2008 21. Sign Funeral Service Licenses 22. Name and Address of Facility
FELLOWS. HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in ach line. immediate Cause (Final Physician androve toput disease or condition resulting in death) 12un /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any lating to find the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-trar and Due to (or as a consequence of) physician at the burial Physiclan/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation or Attending 1 Natural 2 Accident Injury within 24 hours after deau..

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records,

3altimore, Maryland 21215-0036

Hospital

the

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) Amil 2, 208

gton St. Easton, W 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Au W. Monte

egistrar's Signature 2008

		•	For State Registrar	State of Maryl				ealth and N Death	/lental H	ygien Reg. N	7. 4 4 6	3 365
	Physicia /Medic		Decedent's Name (First, Middle, Last, ROBERT BERMON						2. Date of Month	D	ay Year 2008	3. Time of Death 5:23
	Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of Death			c. County of De	
	<u>Ķ</u>		NATIONAL NAVAL		ENTER			THESDA			MONT	GOMERY
\$72	Funeral Director		103-12-00/4	X 7. Age (In	yrs. last birthday) 89 Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of I (Month) May 2	Birth Day, Yea 2, I	918 Ne	irthplace (State or Foreign Country) W Jersey
	pus *	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation						10d. Inside City Limits
	f sho	ō	Maryland Montgome		Gaithers							1 Yes 2 No
	the N 28a-i	Director	10e. Street and Number			10f. Zi	p Code			10a. C	Citizen of What C	Country?
	3a or		419 Russell Avenue	e			2087	7		_	ited Sta	-
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Dece	edent of Hi	spanic Origin? (Spin, Mexican, Puert	pecify Yes or	No-	14. Race - Am	
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydione. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1942-	ir Yes, sp 1 □ Yes		Specify:	o Hican, etc.)		Black, Wh	White
21215-0036	2 hou	Completed	15. Decedent's Edu	ecation	16a. Dece	dent's Us	ual Occup	ation	lein a	16b.	Kind of Busines	s/Industry
215	thin 7 e. an "n Medi	nple.	(Specify only highest grad	College (1-4or 5+)	1		use retired	furing most of wor)	King	U.	.S. Mari	lne
2	ed wil	ő		3	Musi	cian					Band	
ב	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last) Harry Gould Stuar	+				18. Mother's Nan	ne <i>(First, Midd</i> Margar	,	,	
<u> </u>	ould I Men narke	욘		<u> </u>	1 .0. 11							
, Maryland	and 2 sh saith and 27 is n er traun		19a. Informant's Name/Relationship (T) Irene Shively Stu					venue, #				, Zip Code) , MD 20877
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ F	I .	Ob. Place of Dispo cemetery, cre Metro	osition (Na matory or	ame of other plac	e) Apr	Date 10,	20c.	Location - City of	or Town, State
Ĕ	Pag ment ant: l		4 Donation 5 Other (Specify		\ Cre	matoi	clum	; 2	800			a, Virginia
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service Ucens	* thut				ss of Facility De Park Dr			-	MD 20877
	_		23a. P. rt1. E. r. h. sease, or comp s ock, or h. a. f. llure. List only o	lications that caused the	death. Do not en	ter the mo	de of dyin	g, such as cardiad	or respirator	arrest,		Approximate Interval Between
	Physician	2 109	Imme trate Cause (Final		SEPSIS							Onset and Death
	/Medical		disease or emittion resulting in death)	Due to (or as a co			-					
d	Examiner -		Sequentially list conditions.	b								
	p tig	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):							
	ecute and -trans	хаш	that initiated events resulting in death) Last	c Due to (or as a co	needlience of):							
60,	cate be executed physician and the burial-transit			Due to (or as a co	nacquence on.							
68760,		dical		d								
	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p	regnancy						23d. Date of o	delivery
.O. Box	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐ 4☐Pregnant at time		_lEctopic _l Other <i>(</i> :	pregnancy specify)	' 		_	Month	Day Year
0	t the by the ache	hys	9 □ Unknown	9∐Unknown								
S, T	ss tha	by P	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	ınderlying	cause giv	en in Part I.	23e. D	id tobacc	o use contribute	to the cause of death?
ğ	w require been signature								1	☐ Yes	2 ∑ No 3□	Probably 4 ☐Unknown
င္ပ	has be	plet							24a. W	as an	24b. Were	autopsy findings available o completion of cause of
<u> </u>	The cate has page	Completed								erformed?	? death	?
<u>ita</u>	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				55.5	26. Place of Dea	th (Check on	ly one)		
7	Physic this c	2	I les ZX 140		2 ER/Outpatie			4 ⊔ Nursing F	Г		6 □Other (S)	pecify)
Ē	ding Physician: After this certific funeral director,	ü.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o		28c. Injur Wor		28d. Descri	oe how in	jury occurred	
Sic	tend death tor: the f	cati	2 Accident investigation 3 Suicide 6 Could not be	28a Place of injune	At home form of	M root facts		Yes 2 □ No	20f Lagatio	n /Ctract	and Mumbas as	Dural Clauda Musebas
Division or Vital Records, P	or Attendent efter death Director: n by the	Certification:	4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	pecify)	reet, racti	ny, onice		City or	Town, Sta	ate)	Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours efter death. Yo the Funeral Director: After this certifical completely filled in by the funeral director;		(Check only 2 Medical Exam	rsician: To the best of miner: On the basis of exa	y knowledge, dea amination and/or i	th occurre	ed at the tir	me, date and place	e, and due to arred at the tir	the cause	e(s) and manner and place, and c	as stated.
	the	Medical	one) 29b. Signature and title of certifier	and manner stated.			9c. Licens					
	N Vii					-			(374)		Date signed (Mo	
,	114,		2 mo		(Iba 00-) (T	Date to		1243122		1	04/10/2	
	`		30. Name and address of person who can also the second sec	•		, Print)		ATIONAL				TER
	Sta	te_	31. Date filed (Month, Day, Year)	32 egistrar's	Signature		В	ETHESDA	MD_208	89-56	600	
	Regist		4 4	08		1844	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Month **Physician** April 9. Silverman Harry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery The Casey House Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2□ F Oct. 1917 90 15, Director 578-38-6829 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Silver Spring Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 United States 923 Loxford Terrace death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White WW II Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) US Government Accountant permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Gold Isaac Silverman ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 Loxford Terrace Silver Spring MD 20901 Anne H. Silverman - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 4/11/2008 Adelphi, MD 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 Signature of Funeral Sa 0 Part . There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uiscase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【XNo 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice Hospital: 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director. 6 Could not be 3□ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier

Month

Day

Year

3. Time of Death

9. Birthplace (State or Foreign Country) Washington DC

10d. Inside City Limits

Approximate Interval Between Onset and Death

1X Yes 2 No

8:30 PM M

29d. Date signed (Month, Day, Year) D006415 April 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENEVIEVE ANNE WROBLEWSKI, 1355 PICCARD DRIVE, ROCKVILLE, MARYLAND 20850 31. Date filed (Month, Day, Year)

State Registra

32 Registrar's Signature 2008

the

701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 12 **Physician** P M 2008 9:30 April Sprankle Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown 18828 Preston Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Months Hours 1**⊠** M 2□ F May 16, 1937 70 Maryland Director 219-34-5277 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 2 iner must be no with 1 21740 U.S.A. 18828 Preston Road by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. "natural", or iten 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Ticket Agent 7 is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Mae Bricker Albert Guy Sprankle ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. 18828 Preston Road, Hagerstown, Md. 21740 Rose I. Sprankle/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 4/15/2008 Smithsburg, Maryland 4 ☐ Dopation 5 ☐ Other (Specify) of Funeral Sylice Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O<u>ns</u>et and Death Immediate Cause (Final GPAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe 1□ Yes 2 2 No 25. Was case referred edical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 ☐ D**O**A Medical Certification: To 28b. Time of 28c. Injury at Work? filled in by the funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manual of Death 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check or one) 29d. Date signed (Month, Day, Year) 29b. Signature e of certifier DY3590 4.14.2008 Rem BWD smrusbuegh MD 2138 eted cause of death (Item 23a) (Type, Pri 30. Name 22511 00H-5+1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 17, Day 2008 Year **Physician** Mohler РМ Charles Stunkel 4:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kline Hospice House Mount Airv Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 1**X** M 2 □ F Months Hours 03/30/1913 Maryland Director 578-05-2212 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 🏖 ☐ No Directo Frederick Frederick Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 2100 B Whittier Drive, Apt. 404 filed within 72 hours after death Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates:1941–45 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) car dealership 8 auto mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Charles Frederick Stunkel Lena Moler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun 15457 Barnesville Rd., Boyds, MD 20841 Jane Stunkel / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04/22/2008 Frederick, Maryland Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lichniee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician **...** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physiciar Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death Month Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has t irector, page 2 s after death.

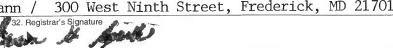
Director: After this certific
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl o Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 1 🗀 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury 28c. Injury at Work? Injury Natural 5 ☐ Pending investigation 1 Natural Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospital or Attending Physician: within 24 hours aft To the Funeral Di completely filled in

> Robert L. Kaufmann / 31. Date filed (Month, Day, Year) State APR 2 5 2008 Registrar

29b. Signature and title



leted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 03 03 08 4:14A M 4c. County of Death 4b. City. Town, or Location of Death Washington Hagerstown 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) Arkansas If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Hours Yrs. 80 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 21 No Hagerstown 10g. Citizen of What Country? 10f. Zip Code 21742 U.S. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Grace Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Harry Shirley Rd KearneysvilleWV 25430 Charlotte Mem. Garden 917 Cemetery Rd. Maetinsburg WV85404

Funeral Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28a-f show any injury or other treumatic event, the Medical Examination of the indiffied at each. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

NMS Health Care

5. Social Security Number

10e. Street and Number

11. Marital Status

10a. State

MD

Directo

Funeral

Be Completed by

411-42-9685

Usual Residence of Decedent

June Lucille Smith

10b. County

14014 Marsh Pike

1 Never Married 2 Married

3 ☑ Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

Ray Smith 20a. Method of Disposition

Washington

15. Decedent's Education (Specify only highest grade completed)

John Bennett Landrum

1 Surial 2 □ Cremation 3 □ Removal from State

19a. Informant's Name/Relationship (Type, Print)

* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Selvice Licenses

4a. Facility Name (If not institution, give street and number)

1 ☐ M 2 🖫 F

Physician /Medical **Examiner**

attending physician and for use as the burial-transit

within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	23a. Party. Enter the disease, or com- shock, or heart failure. List only	one cause on each line.			irdiac or n	espiratory arrest,	J	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a	Kiusini	ian t	215	ease		
	1	Due to (or as a conseq	uence of):	1.11.2 M	1.	C		
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	o, dism				
Cal EAG	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	el death 3 Ectopic				23d. Date of del Month	ivery Day Year
ed by r.	Part II. Other significant conditions o	contributing to death but not res		g cause given in Part I.		23e. Did tobacco		the cause of death?
ollipier.					_	24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of 2 No
	25. Was case referred to medical examiner?			26. Place o	of Death (Check only one)		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Hurs	sing Home	5 Residence	6 ☐Other (Spe	cify)
	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		d. Describe how inju	iry occurred	
0	3 Suicide 6 Could not be determined		iome, farm, street, fact fy)	cary, office	28	f. Location (Street a City or Town, Stat		ural Route Number,
Medical Certification;	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	nysicien: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and ion, in my opinion, death	place, and occurred	d due to the cause(s I at the time, date an	s) and manner as id place, and due	s stated. to the cause(s)
Me	29b. Signature and title of certifier			29c. License number	-	29d. Da	ate signed (Mont	h, Day, Year)
	1 Jan	e meling		006030	96	0,0	10310	8
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)		1	Or	. 6	+

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

-ARID 31. Date filed (Month, Day, Yeer) APR 2 5 2008 ~ Site

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2008 0 Florence Irving Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number) Examiner Dicemica egional Medical ninsula If Under 1 Year If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Days Hours 1 □ M 2 💢 F 08/24/1931 Maryland 76 217-30-9371 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location Items 23a or 28a-f show ner must be notified at 1 Yes 2 □ No Director Wicomico Salisbury MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n USA 21804 200 Civic Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 none Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline Hayman John William Smith ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 221 South Salisbury Blvd., Salsibury, MD 21801 <u>Gerlinda Smith/sister-in-law</u> 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Manokin Presbyterian 4/14/2008 Princess Anne, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee MD ₩00295 11673 Somerset Ave., Princess Anne. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final ASCND Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi The law requires that the death certificate be executed and Due to (or as a consequence of): .O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months 4☐Pregnant at time of death 5 ☐ Other (specify) 1∐Yes 2,⊠No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 2 □ No 2 No certificate Division or Vital Hospital or Attending Physician: the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

217-30-9371

31. Date filed (Month, Day, Year)

address of per

(Check only one)

29b. Signature and title of of

32. Registrar's Signature

9

on who completed cause of death (Item 23a) (Type, Print)

APR 14 2008 100 E.

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

st. Sx1,50 m 21201

		1_ State		rtificate of Death	Reg. 1	2008 1365
		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death Month_	Day Year 3. Time of Death
Physic /Med		Irma Mae Symons		di cii Turani antico et Deci	- L	3, 2008 8:46 a ^M
Exami	iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat Snow Hill	tn ,	Worcester
Funara		5821 Candleberry Lane 5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign Country)
Funeral Director		579-22-0427 1□ M 2□XF 88	Yrs.	Months Days Hours Min	6/28/1919	Maryland Maryland
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. (City, Town or Lo	cation		10d. Inside City Limits
Maryla f shov	ō	Maryland Worcester	Snow Hi	.11		1 ☐ Yes 2 ☑ No
r 28a-	irec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
death with the Maryland rms 23a or 28a-f show r must be notified at	a D	5831 Candleberry Lane		21863		USA 14. Race - American Indian,
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Marylan ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married		Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	Black, White, etc.
urs af urs af sal", or Exami	à	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		
within 72 hours after ene. "natural", or Ite than "natural", or Ite he Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)		. Kind of Business/Industry
within she.	dm	Elementary/Secondary (0-12) College (1-4or 5+) 12 4+	tead			education
IC A Hygie other i	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maid	den Surname)
should be ind Mental marked o	To B	Eugean Taylor			E. Pusey	
<u>10</u> % 25 20	11	19a. Informant's Name/Relationship (Type. Print) Jeanne Shockley/daughter	19b. Maili 582	ng Address (Street and Number or F 21 Candleberry La	Rural Route Number, Ci ane,Snow Hi	ill, MD 21863
her dea		20a. Method of Disposition 20th	b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 200	. Location - City or Town, State
Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Wicomico Park	Memorial 4/		Salisbury, MD
Dallimor permit. Pages ' Department of H Important: If ite any injury or of	5	21. Signature of Funeral Service Licensee	0 2	Name and Address of Facility HOLLOWAY Funeral 501 Snow Hill RC	Home Profe., Salisbu	essional Association ry, MD 21804
		23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	leath. Do not en	ter the mode of dying, such as cardi	iac or respiratory arrest	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	nective	Heart Failure		3,405
/Medica Examine		resulting in death) Due to (or as a con-	sequence of):	Ant Failure	1/2 NC	2045
	E E		sequence of):	evec jaron uns	Jar 1	
cuted nd ransit	Fxaminer	cause. Enter Underlying Cause (Disease or injury that initiated events c				
icate be executed physician and sthe burial-transit			sequence of):			
	legical	d				
BOX (D/Mc	IF FEMALE: 23c. If yes, outcome pf pre 23b. Was decedent pregnant 1 □ Live birth 2 □		□Ectopic pregnancy		23d. Date of delivery Month Day Year
I RECORDS, P.O. BOX of The law requires that the d-ath c-rtiff ate has been signed by the attending age 2 should be detached for us as	Dhyeiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specity)		Month Day Year
hat the did by the detached			resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
dS, uires t signe	2	Al I Matalonial DC			_ 1 ☐ Yes	2 No 3 Probably 4 dunknow
Or VITAI HECONGS, Physician: The law requires tribis certificate has been signe rall director, page 2 should be or	Completed	Asthma			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The la	į	Acquation			performe 1 Yes 2 C	d? death?
/Ital	a	25. Was case referred to medical		Othor	Death (Check only one)	
On or VITal Keding Physician: The law. After this certificate has funeral director, page 2	F	1 Yes 2 No	2 ER/Outpatie		g Home 5 X Residence 28d. Describe how	ce 6 ☐Other (Specify) injury occurred
E g ge	1	5 1 Monatural 5 □ Pending (Month, Day Yea 2 □ Accident investigation				
Division I or Attending after death. I Director: Afte	Cortification.	3 Suicide 6 Could not be determined 28e. Place of injury - A building, etc. (St. 1997)	At home, farm, s	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	00 100		/ knowledge, dea mination and/or	ath occurred at the time, date and pl investigation, in my opinion, death o	lace, and due to the cau accurred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
o the h ithin 24 o the F omplete	Mandi	29a. Certifier (Check only one) 2		29c. License number	. 290	i. Date signed (Month, Day, Year)
7		MS. () mrs		024986	/ md.	4/10/08
(om)		30. Name and address of person who completed cause of death			21801	
	State	Robert J. Reilly MD 560 Riversion 31. Date filed (Month, Day, Year) 32. Faister's S	Signature	IN ANIBORA INC.		
Regi			, It p	Gerell .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Granville Lloyd Tubman .Tr. 8:17 a.^M April 7 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester 8. Date of Birth (Month, Day, Year)
Dec. 30,1912 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1X M 2 □ F Maryland 551-36-2574 Yrs 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Dorchester Cambridge 1 TYes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 Algonquin Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1X1Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) jeweler jewelry store 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; if item 27 is marked other if any injury or other traumatic event, tt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Granville L. Tubman Sr. Naomi Willis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Tubman wife 52 Algonquin Rd., Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Churchyard 4/10/08 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 11 Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. lone روك 700 Locust St., Cambridge, MD 23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diration Meumonia Sequentially list conditions, it are to be a sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trai Due to (or as a consequence of) Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. the a 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Card conyopathy Congestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Parkenson's Disorder 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No page 2 s autopsy Stenosis, and Asthma certificate 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Appatient 2 ER/Outpatient 3 DOA After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

r's Signature

29c. License number

Street Cambridge, MD 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:45 A April 2008 Marie B. Wood 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel South River Health & Rehab. Center Edgewater If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 1 M 2XX Washington, DC 12/7/1911 577-18-5015 96 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Prince George's Riverdale Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20737 4804 Nicholson Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Mamied 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon 12th Hairstylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma O. Rifenberg Oscar Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4804 Nicholson Street, Riverdale, MD 20737 Christa A. Morgan/ Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Kalas Crematory 4/5/08 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home Stry 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Attending Physician:

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical

and attending physician as the use for ned by the a signed I cate has been si this

Be Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

Medical

36 State

resulting in death)	Due to (or as a consequence of):	
Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions DEMENHO AOTHO S		id tobacco use contribute to the cause of death? □ Yes 2□ No 3□ Probably 4 ⊡unknow
Aortic S	pe	/as an utopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check on	ly one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R	esidence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2 No	be how injury occurred
3 Suicide 6 Could not determine	28e. Place of injury - At nome, farm, street, factory, office 201, Locatio	n (Street and Number or Rural Route Number, Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	

29c. License number

5851 Deale Churchton Rd., Deale, MD 20751

29d. Date signed (Month, Day, Year)

Registrar APR 0 8 2008

29b. Signature and title certifier

31. Date filed (Month, Day, Year)

Gyan C. Surana, M.D.

32 Registrar's Signature

30. Name and address of son who completed cause of death (Item 23a) (Type, Print)

	1 - For State Registrar	State of Mary	land / Depa		lealth and N		_	13660
ysician Medical	1. Decedent's Name (First, Middle, Last) Lynda Baker Wi	.lcox				2. Date of Death Month April	Day Year 13 2008	3. Time of Death 11:50a.
aminer	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Dead	h
eral ctor	Chesapeake Woods 5. Social Security Number 6. Sex 160-34-0606	7. Age (Ir	n yrs. last birthday) 68 Yrs.	Cambr If Under 1 Year Months Days		8. Date of Birth (Month, Day,) June 15,	(ear) 9. Birt	hplace (State or Fore untry) Insylvania
sid at	Usual Residence of Decedent 10a. State 10b. County MD Dorchest		c. City, Town or La		kwood			10d. Inside City Limi
Director	10e. Street and Number 3626 Bonnie Lane			10f. Zip Code		100	J. Citizen of What Co	
any njury or other traumatic event, the Medical Exercites must be rediffied at social. To Be Completed by Funeral Director		2. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎗 No	21835 lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit	
t, the Medical E	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work 1) -	ang 16	Sb. Kind of Business	•
Itic event, it	12 17. Father's Name (First, Middle, Last) unknown			nonena	18. Mother's Nam	e (First, Middle, Mi	aiden Sumame)	
ar trauma	19a. Informant's Name/Relationship (Type Seth Wilcox	ре, Print) SON	12621			al Route Number, dens, VA	City or Town, State, 2 23102	Zip Code)
ry or oth	20a. Method of Disposition 1	emoval from State	20b. Place of Dispo cemetery, crer Salisbury	natory or other plac	(8)		oc. Location · City or Salisbury,	
any niu	21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility Th	omas Fune	eral Home MD 21613	P.A.
he burial-transit and lead lead Examiner	disease or condition resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	applifis					works
detached for use as the b r Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2.5 No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3]Ectopic pregлапсу] Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
old be deta	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	,
rector, paue 2 should be de Be Completed by P	Pleur affer Drabetes mel	ctron Otus				24a. Was an autopsy performe	prior to death?	itopsy findings availa completion of cause 2 ☐ No
5 L	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing Ho	th Check only one ome 5 Residen 28d. Describe how	ce 6 □Other (Spe	city)
completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or Town,		
mpletely fill	one) 2 Medical Examin	er: On the basis of exa and manner stated.	y knewladge dean amination and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
8	29b. Signature and title of certifier	losy		29c. Licens			1. Date signed (Mont	
	30. Name and address of person who cou	rowney cause of death	(Item 23a) (Type,	Print)	Line, 2	aston,	4.14.0 MD 2.160	/
State gistrar	31. Date filed (Month, DAPK 1 5	2008 ^{2. Recorar's}	Signature	And	ŕ			

Baltimore, Maryland 21215-0036 $^{\mathscr{M}}$

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 1:10 P arner Virainia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Chesa peake
5. Social Security Number 6. Woods ambridg 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 ☐ M 2 🗷 F Months Hours Dec. 27, 1932 Maryland 215-26-6134 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 PYes 2 □ No Director MD Talbot rappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2958 216 USA Backtown Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. ant: If item 27 is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Someone else's home Work 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pinder ISaac ora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2458 Caubridge Betway- Cambridge Do 21613
ce of Disposition (Name of Date 20c. Location - V of Town, State Warner Mark 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State permit Pages 1 Department of H Important: If ite any in ury or ot once. 12/08 4 ☐ Donation 5 ☐ Other (Specify) Henry Funeral Home, RA.

23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Source (First) 21. Signature of Funeral Service Licensee 22. Name and Address # Facility Approximate Interval Between Onset and Dead Immediate Cause (Final 10 SC ASE Scueraly845 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner s certificate has been signed by the attending physicien and linector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion if cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 X No 1 ☐ Yes To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29d. Date sign d (Month, Day, Year) 30 Name and odress of person completed cause of death (Item 23a) (Type, Print) NARRA 100 Brable

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2151 **Physician** Helen Elizabeth Wright /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 78 Yrs. 13,1929 Maryland 215-26-8982 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marillant Example. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Directo Maryland Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 112 South Prospect St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Elizabeth Miller Heskett A. Hite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Cypress St. Hagerstown, MD 21742 George E. Snyder, Jr-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-15-2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart drillure. List only one cardse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Comery /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of) attending physician by Physician/Medical as the l IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year P in the past 12 months? 5 Other (specify) 2 No the detached 9 Unknown by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 has 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760. The law requires that Division or Vital Records, To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

BH-2

State Registrar

Medical

31. Date filed (Month, Day, Year) **APR 15**

30. Name and address of person who completed of

29b. Signature and title of certifier

29a. Certifier

(Check only one)

istrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7/12-Day Physician Margie Marie Wyatt 0700M 4008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington 11314 Robinwood Drive Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 0270371926 1 □ M 2 🔀 F 82 OH 295-24-8338 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No MD Washington Hagerstown Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 US 11314 Robinwood Drive . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ 3 ☐ Widowed 4 A Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linna H. Lucas Albert E. Snyder ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Tamara E. Moats / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11314 Robinwood Drive, Hagerstown, MD 21742 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Smithsburg Crematory 4/15/2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Euneral Service License 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** terie /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending nevaluism and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 D:No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 Pres 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Charle W.) its II 18) 19, 21102 chim of times at the 224 L 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

17h 13, 2008

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2.00 A 2008 0406 Lee Wilson Emma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Talbot Co. Hospice House Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 X F Maryland 06-30-1924 199-18-7278 83 Director Usual Residence of Decedent 10d. Inside City Limits with the Manyland 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 □Yes 2 No Director Talbot Md. Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9752 Chapel Road 21601 USA Funeral death 14. Race · American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify Black <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Food Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other tha any Injury or other traumatic event, the 1 once. 11 Processing Plant Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Wilson Ann Henry Sampson Harriet 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9752 Chapel Road, Easton, Maryland 21601 Thomas Henry Wilson/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State 04/12/08 Easton, Maryland Chapel Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Furieral Service Licensee 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast months Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760. Physician/Medical yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Drunknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2 No Yes 213KN 1 ☐Yes 1□ 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) Injury 14 Natural 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2816 2003 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 2160 nwood (ne 00 32. Resistrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Amend #1 Reg. No. FH. TCHD, 04/07/08, pha 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year April **Physician** 3153 LAURA REBECCA WHEAT 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Easton Talbot Hospital Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **212–05–6681** 7. Age (In vrs. last birthday) **Funeral** MAY 3, 1910 Months Days Hours Min. 1 ☐ M 2 🛣 MARYLAND 97 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No EASTON TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 USA 32675 DISCOVERY DRIVE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than FLORAL/RETAIL OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOTTIE DEACON URIAH M. WHEAT Wooten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 32675 DISCOVERY DRIVE, EASTON, MD 21601 WILLIE E. WHEAT/HUSBAND Baltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MEMORIAL PARK 4/9/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 21. Signature of Funeral Service Licensee JOHN R. MERLERON 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arrest Due to (or as a consequence of): /Medical Examiner brondogsnic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier asland arn D36644 08 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person MASTANDICA 509 IDLEWILD AZ EASTON MD 21601 JOHN

Registrar

State

31. Date filed (Month, Day, Year)

APR 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Z008 OTIS HERMAN WHARTON, SR. 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death EASTON ALBOT EMORIAL at Easton Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Hours 1**X** M 2□ F 1916 PA Director 218-03-5487 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No TALBOT EASTON MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or 2 r must be n 2 BAKER ST. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No f Yes, Give fear or Dates: 1 Never Married Married o. 1 ☐ Yes 2 No þ 3 □ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 GENERAL MANAGER DAIRY PRODUCTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OTIS HAMBLETON WHARTON MARY ELIZABETH IMLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 BAKER ST., EASTON, MD 21601 MARY C. WHARTON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 4/3/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 21. Signature of Funeral Service License joseph m. Ostre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL OLIGUIZIC Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ₩0 autopsy performe 1□ Yes 2 PNo 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Vinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and s the burial-transit Division or Vital Records, P.O. Box 68760. attending physical for use as t Hospital or Attending Physician:

with the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be in Department of Health and Mental

aryland

Baltimore,

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State Registrar

JOHN BOTSIS M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Monta

oluthetre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifler

32. egistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0099487

29d. Date signed (Month, Day, Year)

04/02/2008

	1 - For State Registrar	State of Maryla		ificate of D		ioniai ii	Reg. No.	2008	1356	
Obvojeje	1. Decedent's Name (First, Middle,	Last)				2. Date of D Month	eath Day	Year	3. Time of Death	
Physician /Medical	Hyungjin David W	00				April		2008	12:30 P	
Examiner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or I	ocation of Death		4c. C	County of Death)	
	1402 Baker Place We				erick			Freder		
eral ctor	5. Social Security Number	5. Sex 7. Age (In) 1 ☑ M 2 ☐ F	yrs. last birthday) Yrs.	Months Days 1 24	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Februar			nplace (State or Fore Intry) Vland	
	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Loca	tlan					10d. Inside City Lim	
5			City, Town or Loca						1 ☐ Yes 2 🛣 1	
Director	Maryland Fred	erick		Frederick 10f. Zip Code		10g. Citizen of What Country?				
ral Di	1402 Baker Place We	st, Apartment 14		·	702		_	United States		
To Be Completed by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1		as Decedent of His ∕es, specify Cuban]Yes 2 ⊠ No	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		4. Race - Amer Black, White, Specify:		
ted	15. Decedent's		16a. Decede	nt's Usual Occupat	tion		16b. Kind	Kind of Business/Industry		
Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+)	(Give kli life, DC	nd of work done du NOT use retired) None	None	^				
	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	(First, Middle	e, Maiden S		<u> </u>	
To Be	Bomoon Woo			İ	Jungshir			,		
F	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing	Address (Street ar			ber. City or	Town State 7	in Code)	
	Bomoon Woo / Fathe								ryland 21702	
	20a. Method of Disposition		b. Place of Disposit cemetery, crema			Date		ation - City or T		
	1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Harmovai irom State			Apri	1 23,	Smit1	nsburg, M	lary land	
	21. Signature of Funeral Service D		mithsburg (Name and Address	of Facility Ke				neral Home	
	D. M.	MO1	1433 10	6 East Chui						
Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	nly one cause on each line.	onary Arres sequence of): Let Right V requence of): r Septal De	entricle	, such as cardiac (or respiratory a	arrest,		Approximate Interval Between Onset and Death	
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre	etal death 3 🗆 E	ctopic pregnancy			23	3d. Date of delive Month	very Day Year	
	Part II. Other significant condition	s contributing to death but not i	resulting in the unde	erlying cause given	in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?	
d by	Cerebral Dysgenesi	Ĺs				1 🗆	Yes 2∏x	No 3∏ Pro	bably 4 🗍 Unknow	
Completed	Cerebral Atrophy					24a. Was	an	24b Mara aut	opsy findings availal	
틽						auto		prior to co	ompletion of cause of	
	Cerebellar Atrophy 25. Was case referred to medical	7			30 Plant (D. 11		2 🖾 No	1 🗆 Yes	2 No	
o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpatient	Othor	26. Place of Death					
Ě	27. Manner of Death	28a. Date of Injury (Month, Day, Year		28c. Injury : Work?	4 Industrig no	me 5 🔼 Hes 28d. Describe			ity)	
iţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		r) Injury		es 2 🗆 No					
Certification: To	3 Suicide 6 Could not determine		 t home, farm, street ecify)			28f. Location (City or To	(Street and wn, State)	Number or Rur	al Route Number,	
	29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex	Physician: To the best of my laminer: On the basis of exam and manner stated.	knowledge, death on ination and/or investigation	n occurred at the time, date and place, and due to the overtigation, in my opinion, death occurred at the time, o			e cause(s) a , date and p	and manner as place, and due t	stated. to the cause(s)	
dical			29c. License	number		29d. Date	signed (Month,	Day, Year)		
Medical	29b. Signature and title of certifier	4 .		D00646	38			il 21, 20		
Medical	29b. Signature and title of certifier	Joon		1 000040	30					
Medical	30. Name and address of person wh		, , , , ,	nt)						
	30. Name and address of person when S. Karen Yoon M.D.	1475 Taney Avenu	ie, #201, Fi	nt)		702	- r -			
completely filled in by the funeral director, page and the funeral director director, page and the funeral director d	30. Name and address of person wh	1475 Taney Avenu	ie, #201, Fi	nt) rederick, M		702		11 21, 20		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KATHERINE LEE WILLIAMS ~ 10 - 2008 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Regional Medical Wicomica Salisbury eninsula Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗶 F Days Hours 73 226-58-7884 VIRGINIA Director 03/02/1935 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MARYLAND WORCESTER POCOMOKE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 ANNE STREET 21851 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🚺 No þ Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN HOPKINS BESSIE WATKINSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH WHITE SISTER P.O. BOX 99, SAXIS, VIRGINIA 23427 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State EDGEHILL CEMETERY ACCOMAC, VIRGINIA 04/13/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign rure / Funeral Service Licensee 22. Name and Address of Facility WILLIAMS FUNERAL HOME 25046 PARKSLEY ROAD, PARKSLEY, VIRGINIA 23421 Approximate Interval Between Onset and Death 23a. 251. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a monsequence of): Zulls /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit Physician/Medical as the attending IF FEMALE: signed by the attendin 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has performe 1 2 100 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 Inpatient 2 ER/Outpatient P 3□ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir 27. Mann f Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) APR 1 4 2008 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Fernando Aele, m.D.

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32. Rafistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

20041211

P.RMC 100 E. Carroll St. Salisbury MD. 218-01

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registra MFND#20aperFH4-11-08,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2008 Year 8, 4:12 P M 05201 Zue 55 man /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 25, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign o, 1923 Pennsylvania Days 1 M 2 □ F 577-22-8972 84 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States 10615 Amherst Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No if Yes, Give Year or Date WW II Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Gerson Icheal Zuessman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 314 Orangewood Lane, Largo, FL 33770 19a. Informant's Name/Relationship (Type. Print) Rona Vazzana, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 04/15/08 1 X Burial 2X Cremation 3 X Removal from State Arlington National Cemetery Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee รือคือการให้เราะ ศีลิธีพัฒน Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Aortic Stenosis disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kidney Disease 2 1 No 3 □ Probably 4 □ Unknown

or Attending Physician: The law requires that the death certificate be executed the burial-P.O. Box 68760, physiciar as attending p for use as Division or Vital Records, rector, page 2 iours after death.

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filled in by the ft.

Funeral

Director

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r items 23a o

the Medical

Department of H Important: If Ite any Injury or ot once.

Physician

/Medicai

Examiner

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene. ant If Item 27 Is marked other than "natural", or items 23a or :

Baltimore, Maryland 21215-0036

Physician/Medical Examine Medical Certification: To Be Completed by

within 24 hours af
To the Funeral D
completely filled i To the 2041

Hospital

		The Part of the Common
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1	(Month, Day Year) Injury Work?	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph	Ussician: To the best of my knowledge, death occurred at the time, date and place, ar niner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year)

D 21340

April 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass, M.D., 3941 Ferrara Drive, Wheaton, MD

State Registrar 31. Date filed (Month, Day, Year) 11 2008 APR



			For State		State	of Ma	ryland			nt of H <i>te of i</i>			lental Hy	-	20	ΠA	10	1570
20	2	q6.	Registrar 1. Decedent's Nam	ne (First, Middle	e, Last)			001	inca	ie or i	Dean		2. Date of De	Reg. No	- E. O	00	3. Time	of Death
	Physici /Medi		Clare L	orena Zir	merli								Month April 9.	Da 2008		Year	21 a	M
	Examir		4a. Facility Name ('If not institution	, give street and n	u <i>mber)</i>			4b. City	, Town, or	r Location	of Death	1271-26		. County o		ier a	
		8			ntist Hospi		4 .			ckvill		0411-			tgome:			
	Funeral		5. Social Security N 213-56-64		6. Sex 1 ☐ M 2 1 F		(In yrs. las	t birthday) . Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		9. Birthp Coun	lace (State try)	e or Foreign
	Director		Usual Residence of				57						Aug 11,	1950				DC
	yland how		10a. State	10b. County			10c. City, T	own or Loc	cation				-			1	0d. Inside (
	e Ma Ba-f s	cto	MD	Montgo	omery			Rockv	ille								1 🗌 Ye	s 2 No
1/2	death with the Maryland ems 23a or 28a-f show r must be notifled at	Funeral Director	10e. Street and Nu 13017 Twin		rkway, #T-2	:				ip Code 853				10g. Cit	tizen of Wi	hat Coun	try?	
MME 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Mar 3 □ Widowed		12. Was De Armed F ied 1 Tyes If Yes, G Year or	Forces? 2 X No Sive		i i		edent of H ecify Cube	ispanic C an, Mexic Specif		ecify Yes or No Rican, etc.)	0-		- Americ , White,		
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$ a_Ve $ Maryland	12 sh h and 7 Is m traum		19a. Informant's N						-				al Route Numb	-			Code)	
	1 and Healt em 2		20a. Method of Dis		d / Daughte	er 	20b. Plac	e of Dispos	sition (Na	ame of			Greenbelt Date		ocation - C		wn. State	
C Baltimore,	Pages ment of ant: If It ury or o			☐Cremation 5 ☐ Other (S	3 □Removal from pecify)	n State		etery, cren Olive	-	,	, i	Apr 14	2008		inatan	-		
Balt	permit. Departimport any Inj once.		21. Signature of F	uneral Service	Licensee			22	. Name a	and Addres	ss of Fac	Franc	cis J. C	ollin	s Fune	ral H	ome In	c.
	E 1181		23a. Part1. Enter	the disease, of	co nplications that	caused t	he death. I						Silver Sport spiratory a		, MD Z	0901	Approxima Interval Be	ate
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	_a B.	REAST	7 0	ANCO									Onset and	d Death
6	Examiner				Due to	o (or as a	consequer	nce of):										
ν 	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease of that initiated event	erlying	Due to	o (or as a	consequer	nce of):										
30,	icate be executed physician and s the burial-transit	I Exa	resulting in death)	Last	Due to	o (or as a	consequer	nce of):				-						
68760,	cate b	edical			d	·												
.O. Box 6	aath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 \(\text{Yes} \) 2 9 \(\text{Unknown} \)	2 months?		birth 2 gnant at t	f pregnanc Fetal de ime of deat	eath 3□	Ectopic Other (s	pregnancy specify)	,				23d. Date Mon		ery Day	Year
Δ.	es that tigned by	by Ph	Part il. Other signi	Ificant condition	ons contributing to	death but	not resultir	ng in the un	derlying	cause give	en in Par	t I.					ne cause of	
ord	requil	ted											11.1	Yes 2	NO :	3 🔲 Prob	ably 4	JUnknown
Division or Vital Records,	steian: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed			·								24a. Was auto perfe	psy ormed?	de	/ere autopinor to coreath? □ Yes		s available cause of
/ita	Physician: r this certific ral director,	Be (25. Was case refe examiner?	rred to medical								ce of Deat	h (Check only			V 40400		
or/	Physic this c	P	1 Yes 2 2	_	-	<u> </u>	t 2 ER	· · · · · · · · · · · · · · · · · · ·	3 🗆 D		4 🗀 Г		me 5□Res				1)	
ion	ath. or: After ne funer	ation:	27. Manner of Dea 1 Natural 2 ☐ Accident	5 Pendin investig	g (Mo jation	e of Injury onth, Day	Year) 28	3b. Time of Injury	М	28c. Injur Worl 1 🔲	yat k? Yes 2[28d. Describe	how inju	ry occurre	ed		
Divis	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral directors.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could r determ	208. Flat	ce of injur ding, etc.	y - At home (Specify)	e, farm, stre	et, facto	ry, office			28f. Location (City or To	Street ai	nd Numbe e)	r or Rura	l Route Nu	mber,
	e Hospit 124 hour e Funera letely fille	Medical (29a. Certifier (Check only one)	1 X Certifyin 2 Medical	g Physician: To the Examiner: On the and ma	ne best of basis of e	examination	edge, death	occurre estigatio	d at the tir on, in my o	ne, date pinion, d	and place, eath occur	and due to the red at the time	cause(s , date an	and mar	nner as st nd due to	ated. the cause	:(s)
	To th within To th comp	Me	29b. Signature and	0	W. H.					9c. Licens					_		Day, Year)	
	3) Ch	while R	Lagrel	2	RAJA	ROPAL	. 2	D42	452	-			2/6			
			30. Name and add	ress of person	who completed car	use of dea	ath (Item 23	Ba) (Type, I	Print) 2	7,	ROLN	A JAC	MAY	ini	9 20	332	1	
wj.	Sta Registi	ite ar	30. Name and add /8 // / / / / / / / / / / / / / / / /	nth, Day, Year)	2008	Registrar	's Signatur	Spa	NE)		-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ABRAMSON **Physician** Isadore 23 2008 7:00P APRII /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. airy MID Frederick (aunty Kline Itospico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 8. Date of Birth (Month, Day, Year) 12/01/1926 5. Social Security Number 6. Sex. 1 ☑ M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Days Hours 168-20-8025 81 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan Internatible and once. 10c. City, Town or Location 10a. State 1 □Yes 2 No Director MD FREDERICK FREDERICK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 USA 1602 BERRY ROSE COURT, #2-B Funeral 12. Was Decedent Ever in U.S. Arqued Forces? 1 [2]Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: 2 3 Nidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN APPLIANCES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WOLFSON **ABRAMSON** BENJAMIN anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 601 SCARLET OAK COURT, WOODSBORO, MD BARRY D. ABRAMSON / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/25/2008 MONTEFIORE CEMETERY JENKINTOWN, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral SOL OL LEVINSON & BROS. ROAD, PIKESVILLE, INC. 21208 8900 REISTERSTOWN Approximate Interval Between Onset and Death 23a. Par 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Immediate Cause (Final CIRRHOSIS **Physician** years diseas or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown EUKEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? e Hospital or Attending Pi 124 hours after death. e Funeral Director: After the letely filled in by the funera After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be To the Hospital or Atte within 24 hours after dex To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State Registrar

10200 VIRGINIA 31. Date filed (Month, Day, Year) APR 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

000 63227

coppermine

4/24/08

Woodsboro, MD

Wayne A. Brown
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02741 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day April 7, 2008 1615 hrs Medical Examiner Wayne A. Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Middle River 72 Benoni Circle 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Min 11/6/60 Director 42 West 1 vM 2 F 47 Yrs. Ind unk Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No marked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at once. Middle River MD Baltimore Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21220 72 Benoni Circle West. Ind. 14, Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 Married 1 Never Married 2 X No West Yes No specify: Specify: Indian Yes, Give Year Yes 3 Widowed Δ Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 721
nent of Health and Mental Hygiene. Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tment of Health and Me rtant: If item 27 is ma y or other traumatic ev Benoni Circle, Millde River, MD 21220 Gloria Smalls/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition timore, crematory or other place) Burial 2 Cremation 3 Removal from State /25/08 Balt., MD Bayview Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Lightsee Hari P. Close f.Svs,PA 21206-5105 5126 Belair Rd, Balt., MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and · Physician/Medical 23a.Pt.II per ME g878 4/29/08 amh X AMENDED attending physician or use as the burial -X UNPENDED Item/7, perFH, C878, 4/28/08, WS The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 V Unknown Thrombotic Microangiopathy of Heart and Brain Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. Be examiner? Hospital: Other: Nursing Home 5 Residence 6 🗸 Other: Scene DOA FR/Outpatient 3 Inpatient 2 this ٩ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No I Director: / Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide within 24 hours at To the Funeral D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. April 8, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year) APR 2 8 2008

ÖRIGINAL

2. Registrar's Signature

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea 25,2008 **Physician** A^{M} 7:00 Bertrand April Edward J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5715 Cynthia Terrace Baltimore Co. Rosedale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 → M 2 □ F 84 Maryland 217-18-0969 28,1924 **Director** Jan. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Rosedale 1 ☐ Yes 2 No Baltimore Maryland · 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 5715 Cynthia Terrace 23a United States 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√No Specify ò 3X Widowed 4 ☐ Divorced WWII White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 8 Years Electrician permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygid Important: If Item 27 is marked other i any Injury or other traumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Bertrand Marie Ruble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5715 Cynthia Terrace Rosedale, Maryland 21206 Carol Fountain (Daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Buria → 2 🗆 Cremation 3 🗆 Removal from State Moreland Mem. Park Cem. 4/28/2008 Baltimore, Maryland **∮** Other (Specify) 4 Donatio 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. nature 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE > 1 YEAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DIABETES MILLETUS 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 MNatural 1 □Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-25-2008 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) 104 David Zajano, M.D. 9101 Franklin Square Drive Baltimore, MD 21237 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

Physician /Medical Examiner

Funeral Director

Carper, Dayles Jumes

3

Patient Known

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Detartment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director

Physician /Medical Examiner

ofan as is ME # 323a town To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

T = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		nt of Health te of Deatl			giene Reg. No.	2008	13671
1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath Day	Year	3. Time of Death
Douglass		James		Camper	III	April	18	2008	02:05AM
4a. Facility Name (If not institution, giv	re street and number)		4b. City	, Town, or Location	of Death		4c.	County of Death	
Circli HONPITU	u of Bril	hinge	Rai	hinger (ita				
5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last birthda)	y) If Unde		er 24 Hins.	8. Date of Birt	th V Year	9. Birth	plece (State or Foreign
217-66-8196	M 2□ F 2	18 Yrs.	Months	Days Hours	New .	08 0	8 '6 '5	9	may) MD
Usual Residence of Decedent									
10a. State 10b. County		10c. City, Town or	Location imore						10d. Inside City Limits
MD NA		Daic	111101	-					1 ₹ Yes 2 □ No
10e. Street and Number			10f. Z	ip Code				zen of What Cou	untry?
2911 Chatham R	oad			21207			ι	J.S.A.	
MD NA 10e. Street and Number 2911 Chatham R 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last	12. Was Decedent I Armed Forces?	Ever in U.S. 13	B. Was Dece	edent of Hispanic C ecify Cuban, Mexic	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 	
X☐ Never Married 2☐ Married	1 ☐ Yes 2 ☑ N If Yes, Give		1 ☐ Yes					_	lack
3 Widowed 4 Divorced	Year or Dates:			21					
15, Decedent's E (Specify only highest gra		(Gi)	ve kind of w	ual Occupation ork done during me	ost of work	ang	16b. Kir	nd of Business/I	ndustry
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						e (First, Middle,		oumame)	
Douglass James						Nichols			
19a. Informant's Name/Relationship		4	-	ss (Street and Num					2121
Nakia Camper-D	aughter	-		rth Ella					
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis cemetery, ci	ramatoni ar	other place)		Date 6/08		cation - City or 1	
4 Donation 5 ☐ Other (Speci		King Me	MOLT	al Patk	4/2	0/00	Nam	Jarroc	Swii y ii d
21. Signature of Funeral Service Lice	男火.[м 2 4	300	wabash	st Ave,	Balti	more	e, Md	21215
23a. Part1. Enter the disease, or com shock, or hear ailure. List only	aplications that called								Approximate
shock, or heart ailure. List only Immediate Cause (Final	one cause on each lir			, ,		. ,			Interval Between Onset and Death
disease or condition resulting in death)	a. HA	spiratio	<u>n</u>						
	Due to (or as	a consequence of):							Same was a second
Sequentially list conditions, if any lauding to immediate	b. Due to ras	a consequence of):	72						4 915
If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Item	u cons - usnos on.	5.24						
that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	-				_		-
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	_d	WE R	Mal.	- der m	40				
IF FEMALE:	22a Huga automa	-1							
23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic				1	23d. Date of deli Month	very Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (s	specify)					
Port II. Other cignificant conditions	contribution to double b	ut mat manufilma in the			4.1	22a Did t	obasso u	ca coatábuta to	the cause of death?
Part II. Other significant conditions	contributing to death b	at not resulting in the	undenying	cause given in Par	Į 1.				
(11V1610)							Yes 2	NO 3 PI	obably 4 Unknown
1-tenan'n's	C					24a. Was auto		24b. Were au	topsy findings available completion of cause of
						perfo	ormed?	death? 1 ☐ Yes	2 D+√6
25. Was case referred to medical				26. Pla	ce of Dea	th (Check only			
examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpat	ient 3 🗆 🛭	OOA Other: 4	Nursing H	ome 5 Resi	dence	6 □Other (Spec	cify)
27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred	
1. Natural 5 ☐ Pending 2 ☐ Accident investigation		y roary injury	М	1 Yes 2	□No				
3 ☐ Suicide 6 ☐ Could not to determined	286. Place of inju	ury - At home, farm,	street, facto	ry, office					ıral Route Number,
4 □ Uounoide	buildi n g, et	с. (<i>эрөспу)</i>				City or To	₩II, SIZIB	/	
1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 6 Could not 1 determined 29a. Certifier 12 Medical Executed (Check only one)	hysician: To the best	of my knowledge, de	ath occurre	d at the time, date	and place	, and due to the	cause(s)	and manner as	stated.
(Check only 2 Medical Exa	miner: On the basis of and manner sta	t examination and/or ated.	investigatio	on, in my opinion, d	eath occu	rred at the time,	date and	piace, and due	to the cause(s)
29b. Signature and title of certifier			2	9c. License numbe	ır		29d. Dat	e signed (Monti	h, Day, Year)
Carillosa	wi-K 1	4.0		PES -	007	0	An	110	9 00 0
30. Name and a ress of person who		leath (Item 23a) (Tvr	oe, Print)	RUJ -			140	ril 18 LhiHov	2008
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State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 10e, 19b-22 per fh g8/9 5-2-08 vt

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						s Drive			wnsv:	ille If Under	24 Hre	2. D. 4.	-4 Dist		ne Aru		
Funeral Director		5. Social Security 217-62-		6. Sex 1 □	м 2∏ F	7. Age (in yis	s. last birthday) Yrs.	Months		Hours	Min.	Mar	of Birth th, Day, Y 29,	ear) 1951	Can	hplace /State or Fountry Califo	
		Usual Residence										1102	,				
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DHMH 17 Rev 1/2001

		For State Registrar		State of	Marylan	•	artment of H		nd Mental I		ne ₂ 0	08	13	676
		Decedent's Name	e (First, Middle	, Last)					2. Date of		-:-	Vasa	3. Time o	f Death
Physicia /Medic		Elva		Mae	Do	orff			April	26,	, Day 2008	Year	1:00	Рм
Examin	er	4a. Facility Name (I		, give street and nun	nber)		4b. City, Town, or	Location of	Death		4c. County Balti			
Funeral		5. Social Security N		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Month	Birth , Day, Y	har)	9. Birth	place (State	or Foreign
Director		212-28-20		1 □ M 2 X F	77	7 Yrs.	Months Days	nouis	August		1930		Virgi	nia
land ow		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation						IOd. Inside C	ity Limits
Mary a-f sh	tor	Maryland	Baltir	nore		Dun	dalk						1 ☐ Yes	2 ∏X No
should be filed within 72 hours after death with the Maryland and Mentale Hygiene. And Mentale Hygiene. I show a marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinational be notified at	Director	10e. Street and Nur		707010			10f. Zip Code 2122	2		10g	. Citizen of USA	What Cou	ntry?	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and once.		21. Signature of Fu			o OPen	Ž	Name and Address Onnelly F	unera:	l Home O	E Du	ndalk	, P.A.	21222	
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of the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)	2 Medical I	g Physician: To the Examiner: On the ba and mann	asis of examina	wiedge, deat tion and/or ir	n occurred at the tin nvestigation, in my o	ne, date and pinion, death	place, and due to h occurred at the t	tne cau ime, dat	ise(s) and r e and place	nanner as , and due	stated. to the cause	s)
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10		30. Name and add	AM20	who completed caus	e of death (Item	(Type,	N, CU	WILLS	Gr Tons	N.0	MD	2120	1	
Sta Registr		31. Date filed (Mor		32. F	egistrar's Signa	ture	rende							

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Martil 23, 2008 4:40PM M Joan Theresa Duquette 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Gilchrist Center TOWSON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 □ F 68 003-30-9277 Yrs 29,1940 New Hampshire Feb. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 🛛 No Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 49 Vista Mobile Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robidas Irene William Duquette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5619 Bayshore Road #144 Palmetto, Florida 34221 Mrs. Lorraine Daley/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/28/08 Towson, Maryland 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 120V3 Small Cll Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No ptû 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed I page 2 s After death. hours after death uneral Director; vely filled in by the f e Funeral C within 2.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra

Physician

/Medical

traumatic event, the Medical Exactiner 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

29a. Certifier (Check only one)

the Maryland

death with

Baltimore, Maryland 21215-0036

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a Jette

15+1 State Registrar

Medical 29b. Signature and title of certifier

and manner stated. 29c License number DS73d3

29d. Date signed (Month, Day, Year) APRIL 26 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charle St TONSON MD 21204

31. Date filed (Month, Day, Year)

APR 28



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For amend 320b Per FH G878 4/28/08 Hment of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 30 **Physician** Ellio 23 2008 amela /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltinone
Under 1 Year | If Under 24 Hrs. akile takin + Kih ank ford Nursing
al Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🛛 F Yrs. 52 lan Director 212-60-8501 la na Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Me Iteal Examiner must be notified at Ba 1 ☐ Yes 2 ☐ No Director lood awn hmore 10g. Citizen of What Country? 10e. Street and Number 21244 U.S 3107 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 FNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify. ò Q 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Chari ranjan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be De rankie ω . ပ္ nus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Perey Elliott 316 lood awn, Md 21244 Drivs-4 ambrid 20b. Place of Disposition (Name Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Balto. Md. 4-29-2008 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility s Fune ral Service P.A. artton Dowelss Fune ral Service P.A. 201 Mc Willah St. Balto. Mg. 21217 21. Signature of Funeral Service Licenses 1201 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause in each line Approximate Interval Between caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burial-trans The law requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗖 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 No the Hospitai or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier N80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sm Woods from 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 04 2008 4:00 P Hazel France /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Summit Park Health Care Catonsville Baltimore 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Davs Hours Director 215-18-3181 86 03/11/1922 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 504 Hilton Avenue Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1
Yes 2 No 1 ☐ Never Married 2 ☑ Married White 1 □Yes 2 No þ Yes. Give Specify. 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Richard Miller Ruby Elizabeth Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar 504 Hilton Ave., Catonsville, Maryland 21228 Lawrence E. France 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State permit. Pages Department o Important: If any Injury or once. <u>=</u> 5 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory 04/25/08 Odeonsville, 122 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 401490 1630 Edmondson Avenue; Catonville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the dath, shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Deat Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a conse uen e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the computer Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying page given in Part I 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate perform 1 □Yes 1 ☐ Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of ath 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. **∠** □ Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Box 68760, o. ₫. of Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending 24 hours after death Funeral Director: filled in by completely within 2

Division

State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of quality

2008

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Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2711 Janet 4lorioso 3008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltonon Gamesis Parkully If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 5 Social Security Number **Funeral** Months Days Hours 1 □ M 2 🎞 F MARYLAND 213-14-5692 9/23/1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No PARKVILLE Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21234 USA 23a 2803 A GLAVIN WAY Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. items 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Maryland 21215-0036 'natural", or Specify. by MI Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical within 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SURVEY TAKER SURVEY 12 should be filed w h and Mental Hygiei 7 is marked other tl 12 TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any Injury or other trainment CHARLES MCABEE MILLER MABEL I. YOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICK LEHMAN/GRANDSON 4703 DUNCREST AVE. BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 4/30/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Euneral Service Licensee TOWSON, MD 21286 8521 LOCH RAVEN BLVD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day hydration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Prompin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed nommers 1c and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DUT aw autopsy performed Chronic distase 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 20 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at After t or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No uneral Director; A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours at To the Funeral D Hospital 1 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated.

State Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

S.ite 4202

29d. Date signed (Month. Dav. Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Chanté Andrea Gaither 1235 PM APRIL 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death n/a BALTIMORE, St. AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 7,1975 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days 1□ M 2 KF 33 Hours Maryland 215-88-3450 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3207 Massachusetts Avenue 21229 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **(**No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MD State Government Data Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christopher Clayton Harris Viola Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Gaither-Husband 3207 Massachusetts Ave. Baltimore,MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Mt. Zion Cemetery 4.29.08 4 ☐ Donation 5 ☐ Other (Specify) 21. Sin ture of Funeral Service Dicen-22. Name and Address of Facility John L. Williams Funeral Directors, 5240 Reisterstown Rd. Baltimore, MD 21215 P.A. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFARCT, LEFT CEREBRAL HEMISPHERE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): LEFT CARETID ARTERY 304x5 HREMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of HYPERTENSION EARS Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death. 1 Yes 2 No 2□ No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

Physician /Medical Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. burial-transit

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the hurini Physician/Medical þ Completed director, page 2 should Be ပ္ Certification:

signed by

certificate has

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Director:

within 24 hours a To the Funeral C

Medical

State

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case examiner?	
27 Manner of	Dooth

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ESPITAL BALTIMERE, MD21229

29a. Certifier

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 □ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGNES.

M.D 31. Date filed (Month, Day, Year)

2 8 2008

32. Registrar's signature

Registrar DHMH 17 Rev 1/2001

Vital Records, P.O. Box 68760 Division or

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year 8:45 PM **Physician** P. Hensen April Jeannette /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Riverview Nursing Home Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. August 17, 1918 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F West 216-01-9542 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County tems 23a or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Dundalk **Funeral Director** Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 101 Kentway 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modical Examinations. 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Distillery Factory Worker 10 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jessie Bollinger Herschel Yost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101 Kentway, Dundalk, Maryland Daughter Barbara Honaker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 29 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Memorial Baltimore, Maryland 2008 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) FUMONIA Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit P.O. Box 68760 attending physician death certificate be Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent prognant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) this certificate has been signed by the are director, page 2 should be detached? 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 1 No To the Hospital or Attending Physician: 26. Place of Death (Check onl one uneral director, 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 ER/Outpatient 3 DOA Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Death After atural 5 Pending 1 atural 2 Accident 1 ☐ Yes 2 ☐ No s after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only completely one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wet Place Dundalk MD 21222 30. Name and address of person who ulle 62. Registrar's Signature 31. Date filed (Month. Day, Year, State Registrar 2008

		1	For State of Marylar		rtment of H <i>rtificate of L</i>			ene 200	8 13683
		_	Hegistrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physicia	_	George R.	Hamm	er, Sr.		April 25		11:47P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	eath
			Johns Hopkins Bayview Medica	al Ctr.		timore		N/A	Otata - Familia
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 133–38–6688 1. ★ 2□ F 67	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent				Jan. 2,1	1941 M	Maryland
	and and	ı		ity, Town or Lo	cation				10d. Inside City Limits
	Mary Ff sh	ţċ	Maryland Baltimore			Dundalk			1 ☐ Yes 2 反 No
	or 282	Directo	10e. Street and Number		10f, Zip Code		10	g. Citizen of What	Country?
	23a c		8152 Bullneck Road		212			United S	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
20	filed within 72 hours after death with the Maryland Hygiene. Hygiene. bther than "natural", or items 23a or 28a-f show ent, it is Mariked Examiter must be redified at ent.	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify:	White
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7 7	d with giene	mo.	12 Years	Ins	urance Aç			Insurar	ice
		Be	17. Father's Name (First, Middle, Last)				e (First, Middle, M.	aiden Surname)	
<u>Xa</u>	should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show is marked other than "natural" or items to reflice a strumatic event, the Marsleaf Exercitor must be refliced at	၉	George Leroy Hammer				ce Smith		7.01
Maryland	2 sho s and is m raum		19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street a</i>		ral Route Number, Dundalk,		
e) O	l and lealth im 27		Mrs. Jean M. Hammer (Wife) 20a. Method of Disposition 20b.					Oc. Location - City	
وّ	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic evonce.		1 Burial 2 Cremation 3 Hemoval from State		osition (Name of matory or other place		0/2000	Dotagon	Maryland
Baitimore,	iit. Pa artmei artant injury		4 □ Donation)5 □ Silver (Specify) H: 21. Signature of Jungs I Service Licensee	-	Service C	ss of Facility			
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J.	Physician	î n	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	louli.	Campacia	allen	dieas	P	Onset and Death
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	ם יב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	wence of):					
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×	Physician: The law requires that the death certificate this certificate has been signed by the attending rail director, page 2 should be detached for use as		IF FEMALE: 23c. If yes, outcome of preg. 23b. Was decedent pregnant	nancy [*]				23d. Date of	delivery
Вох	death a atte	iciai	in the past 12 months?		☐ Ectopic pregnanc ☐ Other (specify) _	У		Month	Day Year
P. O.	t the oby the ache	Physician/M	9 Unknown						
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<u>=</u>	The cate h	Con	Orabeles Mellitus				perform 1 □ Yes 2		Yes 2 PNo
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Division of Vital Records,	Physical direction	은	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ 27. Manns of Death 28a. Date of Injury	28b. Time	int 3 LI DOA	4 L Nursing H	lome 5 Reside	nce 6 □ Other (w injury occurred	Specify)
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<u> </u>	al or / after Dire	Certification: T	4 Homicide determined building, etc. (Spec	сіту)			City or Town	i, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, dea	th occurred at the ti	ime, date and place	e, and due to the curred at the time.	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	the Hi in 24 the Fu	Medical	one) and manner stated.						
	With Volume	Σ	29b. Signature and title of certifier		29c. Licens	se number +1399		9d. Date signed (A	70 P
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	12		30. Name and address of person who completed cause of death (It	tem 23a) (Type	Print)	+ Blow	ste 724	Boit	マルンケ
	« Sta	ate.	31. Date filed (Month. Day, Year) 32 Registrar's Sig	inature	7 -4	· · · · /	V 1	9-11	
	Regist		APR 2 8 2008 Hours	S. Se	ade				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Day **Physician** KATHERINE HERTZFELT THERESA 9:06 P M April 23 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER BERLIN NURSING CENTER BERLIN if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 3/26/1920 Days Hours 1 ☐ M 2 🔀 F MARYLAND 88 Director 217 03 9431 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 🛣 No Director MD WORCESTER OCEAN CITY 10e. Street and Number 10g. Citizen of What Country? "natural", or Items 23a or idical Examiner must be 12346 OLD BRIDGE ROAD #208 21842 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ WHITE Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL BUS DRIVER TRANSPORTATION 6 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other 1 any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RACHEL PATTERSON JOSEPH J. KOLARIK R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #204 19a. Informant's Name/Relationship (Type, Print) 12346 OLD BRIDGE ROAD OCEAN CITY, MD 21842 JUDITH A. SWINGLER/DAUCHIER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY REDEEMER CEM 4/28/08 BALTIMORE, MD 21. Signature of Funeral Service Lice isee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Terre /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erries Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician ar Physician/Medical ası attending for use as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably Unknown has been si le 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page certificate 1□ Yes Physician: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 3 □ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P After this 27. Manner of Death 1 Matural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P s after death. Certification: (Month, Day Year) Injury 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 20 rodulin 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

				State of Marylan				ental Hygi	ene _{2 n n R}	13685
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Date of Death	g. No	3. Time of Death
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arylan show	roj Pi	_	10a. State 10b. County	_	y, Town or Loc					10d. inside City Limits 1 ☐ Yes 2 ☐ No
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r deatl		Funeral Directo		. Was Decedent Ever in U. Armed Forces?	S. 13. V		lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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arylo		<u> </u>	19a. Informant's Name/Relationship (Type	Print)	19b. Mailin	g Address (Street	and Number or Rura		City or Town, State,	Zip Code)
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00-			20a. Method of Disposition / 1⊠ Burial 2 □ Cremation 3 □ Ren		lace of Disposemetery, cren	sition (Name of natory or other place	ce) ¦		Oc. Location - City or	
Baltimc permit. Pag Department Important: fi	n d		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Car	rison Fo	Name and Addre		1-2008	Baltimore Service Po	1 Ma.
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BOX 6 Beath certific attending p	200	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome pf pregna		I=:-			23d. Date of de	livery
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LIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this commission filled in by the funeral dis	ierery :	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physic 2 ☐ Medical Examine	ian: To the best of my kno r: On the basis of examina and manner stated.	wieage, death tion and/or inv	restigation, in my c	ppinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
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141			30. Name and address of person who com	to to A c			Caher	10 10	h Green	,2008 St,21201
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signar		le	cont v	1 - 1 4 4 .		, , , , , ,
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			For State Registrar	State of M		/ Depa		Health and f Death	Mental Hyg	iene 2	008	13686
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ı	Funeral Director		215-22-0434	1 □ M 2 □XF	81	Yrs.	Months Day	s Hours Min	8. Date of Birth (Month, Day, Oct. 19		Coun	ryland_
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				11	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number		1		10f. Zip Code	9	1	0g. Citizer	of What Coun	try?
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36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	X No		1∐Yes 2∑XN			Sp	necify:	
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. 2ther than "natural", or items 23a or 28a-f show ent, the Medical Evander in the paraffied at	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	kind of work don DO NOT use reti	ne during most of wo		TOD. TAITO	or Dusiness/inc	idon y
212	withi jiene. r thar	mo	Flementary/Secondary (0-12) 7 Years	College (1-40)	r 5+)	Fac	tory Wor	ker		Manu	facturi	ng
פַ	be filed within 72 hours after death with the Marylan tal Hygiene. Independent than "natural", or items 23a or 28a-f show event, the Medical Evan in the nutition at	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle, I	Maiden Sui	rname)	
<u> </u>	Mental Mental arked o	70 E	William LeBr	cun				Kathr	ine Bohle			
Maryland	es 1 and 2 should be i of Health and Mental If item 27 Is marked o r other traumatic eve	v į	19a. Informant's Name/Relationship Mr. Milton J. Duc)			et and Number or F Road Esse			own, State, Zip 21221	Code)
ď	theal f Heal frem 2		20a. Method of Disposition	(2 - 12			osition (Name of matory or other p				tion - City or To	wn, State
9	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Denation 5 ☐ Other (Spec	Removal from State				e Corp. 4,	/26/2008	Tow	son, Ma	aryland
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of meral Service Lie				2. Name and Add Duda-Ru	dress of Facility	al Home o			
	20 = # O		1 9/0801	full		D	7922 Wi	ise Ave.	Dundalk,	Mary	land 2	
			23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each					ac or respiratory em	6 51,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	_ a	s e onseque		hom	N FI				gears
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×	certifica nding ph ise as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnanc	су				230	d. Date of delive	arv
ROX	death e atten id for u	iciar	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant	2 ☐ Fetal d at time of dea		☐ Ectopic pregna ☐ Other (specify)				Month	D <i>a</i> y Year
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	w requires that the disbeen signed by the should be detached	by P	Part II. Other significant conditions	contributing to death	but not resulti	1 0		given in Part I.			_	ne cause of death?
ecords,	equir een s ould	ted	A	cs of ces	J., C	<u>0 V 0 V</u>	iny is	// -	. 1∐Y€	es 2 -1 1	No 3∐ Prot	oably 4 ☐ Unknown
ပ္	0 8 0	Completed	VISEASE, CO	nyest	ne /	Un	7 Jan	clus	24a. Was a autops	sy	prior to co	psy findings available mpletion of cause of
	ician: The l certificate ha ector, page	Co							perform 1 □Yes	2 No	death? 1 ☐ Yes	2 🗆 No
Vital	iding Physician: th. : After this certifica : funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Other:	eath (Check only on			Hazza
	Physer this eral di	5	1 Yes 2 No 27. Manner of Deeth	28a. Date of Ir	itient 2 El	R/Outpatie 8b, Time o	of 28c. In	4 □ Nursing njury at	Home 5 Reside			meros pice
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5	ital or irs aft ral Dir lled in											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral by the	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medicel Ex	Physician: To the be- aminer: On the basis and manner	of examination	edge, deat on and/or in	th occurred at the nvestigation, in m	e time, date and pla ny opinion, death occ	ce, and due to the c curred at the time, c	cause(s) ar date and pl	nd manner as s ace, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	110	2	. 1	29c. Lice	ense number	2	29d. Date s	signed (Month,	Day, Year)
			1/ HATA	m/luc	700	w	112	1 201	1	TOV	1667	, 2005
	12		30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type,	V. Ch	noles	t. Bali	40.0	ud i	2008
	Sta		31. Date filed (Month, Day, Year)		strar's Signatu	re A	وجمعه					
	Registr	ar	APR 282	UUO DEL	ies sis	No.	-					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:25 P M 2008 Kelly April 21, H. Wonita /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Co. Rel Air Lorien Bel Air Nursing & Rehab 8. Date of Birth
(Month, Day, Year)
July 21,1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours Min 1 □ M 2 😡 F Days 85 Pennsylvania Director 187-16-1624 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State show in than "natural", or items 23a or 28a-f show Bel Air 1 ∏Yes 2 to No Harford Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 United States 1909 Emmorton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2√☐No Specify <u>></u> 3 € Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Dieroff Jonathan Herb ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4810 Water Park Drive Belcamp, Maryland 21017 Judith Muhl permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4/24/2008 Baltimore, Maryland Gdns of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a o. I Yes 2 □ No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown SIDEROBLASTIC ANEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ၀ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural al or Attendi after death. I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 345344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD , 622 S. UNION AVE, HAVRE DE GRACE SURESH DHANJANI 31. Date filed (Month, Day, Year) APR 2 8 2008 State Coaste Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** 0820 AM 19 Harry Edward Keyser ADril /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Woshington Medical Glen Arunde Burrie Anne Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O4/14/1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 ☐ F 218-09-5871 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o e 21122 U.S.A. 230 Dale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver WT Cowans Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry A. Keyser Emma Matilda Kalter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Mohler/Daughter 250 Wanda Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Pk 04/25/08 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Obstructive VulmonAny hseuse Physician Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Due to (or as a consequence of): Physician/Medical IE FEMALE: If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) __ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? res 2 No death? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Division or Vital Records, P.O. Box 68760, as or this certificate has within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

r 28a-f show notified at

"natural", or Items 23a edicai Examiner must t

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State

Registrar

29c. License number

YMSAdeNA

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christophen deborja 3708 MOUNTAIN Rd.

31. Date filed (Month, Day, Year) APR 25 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 24, 2008 8:30 P M Cecelia April Los /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2004 Codd Avenue Baltimore Dundalk 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1926 1 □ M 2 F Months Days Maryland 82 January 7, 212-20-0380 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a. State 10b. County 28a-f show 1 ☐Yes 2 XNo Directo Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 2004 Codd Avenue 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 🛛 No If Yes Give Specify: 2 Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 6 Years Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Item 27 is marked or r other traumatic eve George Albert Rolnick Maryanna Catherine Wanrzyniak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Stogoski Daughter 2004 Codd Avenue, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) AprilDate 29. 20c. Location - City or Town, State Pages 1 permit Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State Baltimore City, MD. Bayview Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road Dundalk, MD, nthone 23a. Part 1. Enter the disease or complications that caused the demanded by Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myozardenl **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner carcherapula Yeus trenevalente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and burlal-tra Due to (or as a consequence of) Box 68760. attending physician for use as the burla certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed STEWUSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? levy cove 1 ☐ Yes 2 ☐ Mo 1 ☐Yes 2 ☐No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No al or Attend after death Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26394 Wandel I'm ted cause of death (Item 23a) (Type, Print) IV. CHARLES LEIN 6535 DUNBED T 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 5 2008

State Registrar 31. Date filed (Month, Day, Year)

APR 2 8 2008

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AMIRA WOHAMMED STYAM, N.D. UNION HEMORIAL HOSPITAL, BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		1	For State		State of	of Mary	/land / l		rtment o			Mental H	ygiene .Reg. No.	/ 11	08	13691
-		1	Registrar Decedent's Name (First, Mide	dle. Last.)			0071	inouto c	-		2. Date of D	Death			3. Time of Death
	sicia	n		Link								Month April	25	2008	Year	7:00PM M
70.0	ledica amine		a. Facility Name (If not instituti			ımber)		Т	4b. City, Tow	n, or Loca	ation of Deat			County o	f Death	7.100
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Fune	eral	5	. Social Security Number	6. Se		7. Age (I	n yrs. last b		If Under 1 Ye Months Da		Jnder 24 Hrs ours Min.	8. Date of E (Month, I	Day, Year)		9. Birthpl Coun	lace (State or Foreign try)
Direc	tor	1	212-10-2721	'	M 2 F		92	Yrs.				Dec.	12, 19	915	Mary	land
and		- 1	Usual Residence of Decedent 10a. State 10b. Coun	ty		10	0c. City, Tov	wn or Loc	ation						1	0d. Inside City Limits
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the 1	notif	Director	10e. Street and Number						10f. Zip Cod	de			10g. Citi	izen of W	hat Coun	itry?
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21213-0036 Within 72 hours after death with the Maryland plene. r than "natural", or Items 23a or 28a-f show		Funeral	11. Marital Status		12. Was De Armed F	cedent Eve	er in U.S.	13. V	as Decedent Yes, specify	of Hispar Cuban, M	nic Origin? (S lexican, Pue	Specify Yes or to Rican, etc.)	No-	14. Race Black	 Americ White, 	
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15-0036 72 hours af "natural", or	Exa	d by	3 XWidowed 4 ☐ Divorce 15. Deced		Year or	Dates:	16	a. Deced	X ent's Usual O		1		16b. K	ind of Bus	Whi siness/Ind	
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e filed	ent,	BeC	17. Father's Name (First, Midd	le, Last)						18.	Mother's Na	ime (First, Midd	dle, Maiden	Surname	9)	
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Maryland 2 nd 2 should be filed if and Mental Hygid	anma		19a. Informant's Name/Relation	nship (7	ype. Print)		19					Rural Route Nu				1
or Health of Health Item 27 I	ner tr	_	Terry K. Sull	<u>ivan</u>	/Guard	lian_	20h Place		orth C		rt St.	Baltir	nore,	Mary	zlanc	3 21202 own, State
MOFE Pages 1 nent of H int: If Ite			20a. Method of Disposition 1☑ Bunal 2 ☐ Crematio	n 3 🗆	Removal from	n State	ceme	tery, crer	natory or othe	r place)	111				-	
Baltimore, Maryland 2 sermit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie mportant: If Item 27 Is marked other t	juny	-	4 Donation 5 Other				St. S		.slaus			29/08 Duda-Ru				Maryland dalk, Inc.
Baltimo permit. Page Department Important: If	any injury o		21. Signature of Funeral Servi	ce Licen	see	A -	~					Dundall				
		-	23a. Part1. Enter the disease	or comp	dications that	t caused th	ne death. De	o not ent	er the mode o	f dying, s	uch as cardi	ac or respirator	y arrest,			Approximate Interval Between
Dharais	Ion		shock, or heart failure. I	ist only i	one cause or	i each line.	•									Onset and Death
Physic /Med			disease or condition resulting in death)	-			COVASC consequenc		Acci	dent						1 Month
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cate I	the t	dical		•	d											
I Records, P.O. Box 68 The law requires that the death certifics tte has been signed by the attending ph	ise as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes,				7					23d. Dat	te of deliv	
Box leath cert attendin	should be detached for use	ciar	in the past 12 months?		4□Pre	egnant at ti	Fetal death		∃Ectopic preg ∃Other <i>(spec</i>				_	Mo	nth	Day Year
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s that	e det	by P	Part II. Other significant con-			death but	not resulting	g in the u	nderlying caus	se given i	n Part I.					the cause of death?
ord aquire en sig	d bluc	edt	Senile Dem	enci	.a							_ 1	☐ Yes 2	² ★ ^{No}	3 ☐ Pro	bably 4 Unknown
Division or Vital Records, i or Attending Physician: The law requires t after death. Director: After this certificate has been signe	2 sho	Completed										– l a	Vas an lutopsy	1 1	prior to c	opsy findings available opposed in the completion of cause of
The The	page	Com										1 T	erformed? es 2 N		death? 1 ☐ Yes	2 No
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/ision Attending r death.	y the	fica	3 Suicide 6 Co	uld not b	e 28e. Pla	ace of injur	y - At home	, farm, st	reet, factory, o	office		28f. Location	on (Street a	and Numb	er or Ru	ral Route Number,
Div after	d in b	Certification:	4 [] Hollicide		, DC	ilding, etc.										
To the Hospital o	completely filled in by the funeral director, page 2		29a. Certifier 1 Cert	ifying Ph	nysician: To	the best of	f my knowle examination	dge, dea and/or in	th occurred at	the time,	date and plaining	ace, and due to ccurred at the t	the cause ime, date a	(s) and mand indicate,	anner as and due	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 24, 2008 7:50 A.M April Dorothy M. Mohr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Catonsville Frederick Villa Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 92 Sept. 1915 Maryland 216-01-8202 Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 XNo Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2816 Still Leaf Lane 21042 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Completed by 3 NWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Development Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Baker Hugh Gartrell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandy Cornelius-Daughter-in-Law 2816 Still Leaf Lane; Ellicott City, MD 21042 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/2008 Woodlawn, Maryland Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Incens 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the direas shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Due to (or a Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending property for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy 2 | Fetal death 1 Live birth Month Year in the past 12 months?
1 Yes 2 DNo
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform certificate 1∐ Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ၉ After this 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 27. Mannes of Death atural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

29a, Certifier

29b. Signature and title of cartifier

MANL

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Year)

APR 2 8 2008

32 Registrar's Signature

Medical

To the Hospital of within 24 hours at To the Funeral C

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANE E. MELLOTT /Medical Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner -ranklin Date of Birth (Month, Day, Year) ge (In vrs. last birthday) Security Number **Funeral** Months Days Hours 1□ M 2🔽 F Director 215-34-5010 1/31/1932 WASHINGTON. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show must be notified at 1 ☐ Yes 2 ☑ No MIDDLE RIVER **Funeral Director** BALTIMORE MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a 21220 USA 3402 DAHLIA LANE American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: ō 1 ☐ Yes 2 ☐XNo Specify: altimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced WHITE natural", 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than OWN HOME HOMEMAKER 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental I GRACE A. KRIEGER JOHN LYONS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MIDDLE RIVER, MD 21220 RONALD F. MELLOTT/HUSBAND 3402 DAHLIA LANE 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place
DULANEY VALLEY MEM Important: If it any injury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4/29/2008 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS 22. Name and Address of FacilityTHE JOHNSON FUNERAL HOME, P.A 21. Signature of Funeral Service Licensee 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dec 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕱 No the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 2 No Hospital or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 2 ER/Outpatient 3□ DOA 1 🔲 Yes 2 No 1 Inpatient P this in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

Director: After the 27. Manner of Death Certification: Injury (Month, Day Year) 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) Baltimore Md 5

Registrar

DHMH 17 Rev 1/2001

State

(Month, Day,

ORIGINAL

32. Registrar's Signature

Exami Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23 or 28a-f show any injury or other traumatic event, I'm Madical Examination must be notified at aging or other traumatic event, I'm Madical Examination must be notified at aging. Baltimore, Maryland 21215-0036

Physic /Medi

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - For State of Maryla Registrar		artment of Health rtificate of Deat			giene Reg. No.	008	13694
an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		Year	3. Time of Death
cal	ALLÁN		MASTER		APRIL	24	2008	7:50A M
ner	 Facility Name (If not institution, give street and number) 9050 IRON HORSE LANE, APT. 30 	5	4b. City, Town, or Locatio			4c. Cc	ounty of Death BALTII	
۳		3 . last birthday)	If Under 1 Year If Und	er 24 Hrs.	8. Date of Birt	h , ,	9. Birth	place (State or Foreign
	193-20-1023	Yrs.	Months Days Hours	s Min.	07/11/	1928	Cou	PA
	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Ď		IKESVII						1 □ Yes 2 🛣 No
irec	10e. Street and Number	TICLOTTI	10f. Zip Code			10g. Citizer	n of What Cou	intry?
Funeral Director	9050 IRON HORSE LANE, APT. 30	5	21208				USA	
unei	11. Marital Status 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married	J.S. 13.	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
	1 ☐ Never Married 2 🕅 Married 1 🛣 Yes 2 ☐ No K 🕻 Û 1 f Yes, Give 3 ☐ Widowed 4 ☐ Divorced 1 € 7 e a r or Dates:	KEA	1 □Yes 2 🛣 No Speci		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			WHITE
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	and of world		16b. Kind	of Business/Ir	ndustry
mple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done during m DO NOT use retired)	iost of workir	ig		4.5	_
S	12 17. Father's Name (First, Middle, Last)		SALES	ther's Name	(First, Middle,	Maidan Cu	AR'	l
To Be	SAMUEL	MASTEI		ELYN	(First, Middle,	Maidell Su	mane)	STYER
-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and Nun	nber or Rura	i Route Numbe	er, City or T	own, State, Zi	ip Code) 21208
	BARBARA MASTER / WIFE		IRON HORSE					
	1 Burial 2 □ Cremation 3 □ Removal from State	cemetery crei	osition (Name of matory or other place)		ate		tion - City or T	
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service icensee	EMURIAI	PARK 2. Name and Address of Fac	04/25,	L LEVIN		ALLSTO	
	Vau allur		8900 REISTERS					
	23a. Part J. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	3	Cardiomy	o par	thy			Onset and Death
	Due to (or as a conse		Artern Di	reero.	'			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):	Artery Dis Renel Dis	, - ,-				
xami	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse	ege	Renel Dis	essi				
edical Examiner	230 10 (01 da d 301100	quorioc oi).						
ledio								-
an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1 □ Live birth 2 □ Fe		☐ Ectopic pregnancy			230	d. Date of deliv	•
Physician/M	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of 9 □ Unknown 9 □ Unknown		Other (specify)				Month	Day Year
	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Par	rt I.	23e. Did to	bacco use	contribute to	the cause of death?
Completed by					1 🗆 Y	es 2 🗌	No 3□ Pro	bably 4 hknown
plete					24a. Was		24b. Were aut	opsy findings available
Jom C					autop perfor	med? 2 A No	death?	ompletion of cause of 2 □No
Be (25. Was case referred to medical examiner?		26. Pla	ace of Death	(Check only o			
	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐			1	ne 5 🕅 Resid			ify)
Certification: To	27. Manneyof Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Accident investigation	28b. Time o Injury	f 28c. Injury at Work? M 1 ☐ Yes 2		28d. Describe h	ow injury o	occurred	
ifica	3 Suicide 6 Could not be				28f. Location (S	Street and f	Number or Rui	ral Route Number,
Cert	4 ☐ Homicide determined building, etc. (Spec	aty)			City or Tou	n, State)		
Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the time, date vestigation, in my opinion, o	and place, a death occurre	and due to the ed at the time,	cause(s) a date and pl	nd manner as lace, and due	stated. to the cause(s)
Me	29h Signature and title of certifier		29c. License numbe	er		29d. Date s	signed (Month,	, Day, Year)
	Deaviles A	10		6155			4 24	08
	30 Name and address of person who completed cause of death (Ite PARIKH MD	m 23a) (Type,	MAN ST, R	LEIST	ERSTU	NN	, MD 2	21136
ite ar	31. Date filed (Month, Day, Year) 32. Registrar's Sign		7,					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month April 25, 2008 Ann G. Nordhoff 5:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 2, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 M 2 XF Director 219-12-9707 83 1924 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified et 1 ☐ Yes 2 TNo Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt CC123 21228 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married I ∐ Yes 2 ⊠ No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Librarian College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill deelth end Mental Him 27 Is marked oth Clarence P. Goetz Mary Nagengast 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth er Important: if Item 27 Is eny Injury or other treu once. F. Charles Nordhoff Husband 715 Maiden Choice Lane Apt CC123; Catonsville,MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Loudon Park Cemetery 4/30/2008 Baltimore, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility terling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1101490 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Minoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of) ettending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Tetal death 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Hoursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After 1- Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erin 30 Name and address of person who completed cause of death (Item 23a) (Type, Print house Care, Calongore our 31. Date filed (Month, Day, Year) State APR 2 8 2008 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1- State amend #1 Per Phy G878 4/28/08 OFF rtificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** 2008 Robert Oliver 24 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** HOSPIT BALTIMOR ARBOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) ocial Security Number Funeral 1**∑**M 2□ F Months Days Hours 10/28/1933 74 Maryland Director 218-28-1655 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 XNo Directo Baltimore Catonsville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r U.S.A. 21228 112 South Symington Avenue death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coppin College 12 Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 John C. Oliver Sadie Evelyn White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diania Dabney / Niece 2700 West Garrison Ave., Baltimore, Maryland 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/03/2008 Lansdowne, Maryland Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ultiple /Medical Due to (or a a consequence Examine RESPIRATORY Falium HYPOXEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed 7 608 and attending physician Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gentiler BABAK BEDATAT, 29c, License numbe 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) BALTIMORE MD, 21225 S. HANOVER STR. 3001 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 369 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Reed Yea :02 PM ames 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health + Rehab Ctr Himore Ba If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□ F Director 215-30-0969 2/8/35 GA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at N/A Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 Harlem Ave 21223 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Specify African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ American Completed marked other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Elementary/Secondary (0-12) College (1-4or 5+) Trucking 11 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O. Reed 127 is marked er traumatic e Julia Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3609 Harlem Ave, Baltimore, MD permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Eunice Johnson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/08 Western Cem Baltimore, MD 5 Other (Specify) 22. Name and Address of FacilitHari P 21. Signature of June al Service Licensee 22. Name and Address of Facilitari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any reading to increaling to increaling cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ins certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) ₹ No 2 ER/Outpatient 3 DOA Certification: To 1 TYes 1 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 2 🗆 No hours after death. investigation 1 Yes 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

Division or Vital Records, P.O. Box 68760,

within 24

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 2 8 2008

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3, Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) APPIL ROACH 5:31 PM Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RBOR SALTIMOR If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 M 2□F Months Days 09/28/1925 Maryland 213-20-8441 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State 1 ☐ Yes 2 No Director Anne Arundel Pasadena MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or a lamp hjury or other traumatic event, the Medical Examiner must be mone. U.S.A. 21122 226 Carvel Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1944 - Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1946 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors 12 Wireman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madge Myers John S. Roach 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 226 Carvel Road, Pasadena, MD 21122 Leona Roach / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/26/08 Glen Burnie, MD Glen Haven Mem Pk 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Emeral Service Licenses 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical LUNG DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Example 1 Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) DMITSI
300 | SOUTH HAWOUER STREET BAL

APR 25 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3State of Maryland / Department of Health and Mental Hygiene 20a, b per dr/fh. 8878, 04/28/08dhb Reg. No. 2 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:15p ^M : 2008 npmy H /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner raven Blvd Apt505 altimore 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 157-14-8605 1**□**₩ 2□ F 81 Director 10-2-1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural" or item any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA 14. Race - American Indian, 6201 Loch haven Blvd Apt 505 21239 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Ne Specify: þ Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Omni Consultan resident 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be iman H. Styles, Sr Styles Bessie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4009 houndtop hd Baltimore, MD 21218

ce of Disposition (Name of Date 20c. Location - City or Town, State Melanie 20a. Method of Disposition I cameter cremator or other place)
Lansdale Crematory

Lorthwood Complexy 1 □ Burial 2 ★ Cremation 3 □ Removal from State Address of Facility Vaushn C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 4905 York had Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in pach line. Immediate Cause (Final REATIC NOCA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2►No 24a. Was an autopsy performed? certificate 2 🗷 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€No 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Il Director: A 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after Funeral 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 the 29c. License number 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

31. Date filed (Month, Day, Year) APR 2 8 2008 101

person who completed cause of death (Item 23a) (Type, Print

Registrar's Sign

08-03116 Andrew Ray Sturgill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hydiene

drew Ray Sturgill		State of	Maryland /	Depart Certi	tment of <i>ficate of</i>	Health and Death	Mental H		eg. No.	2	008	1370
	Re	istrar Decedent's Name (First, Middle,Last)						2. Date of Dea	th	Year		me of Death
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Euporal	5.	Social Security Number 6. Sex		(In yrs. las	t birthday)	If Under 1 Year			rth(MM/	DD/YYYY) !	g. Birthplac Foreign	e (State or
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Maryland 28a-f show datonce.	1	e, Street and Number	1			10f. Zip Code			10g. Citi	izen of Wha	t Country?	
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death with the Maryland or items 23a or 28a-f sho must be notified at once.			12. Was Decedent	Ever in U.S	s. 13. Wa	as Decedent of His	spanic Origin? (S	Specify Yes or N	lo-	14. Race - White,		Indian, Black,
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136 hin 7 than than	<u> </u>	11			Car	penter				Const		<u>on</u>
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner) I '	7. Father's Name (First, Middle, Last)					18.Mother's Nan					
21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medical or Defermination of the property of the Medical or Defermination or Defermination o	e l	James Sturgill				ng Address (Stre	Doro	thy Turi	er	Taylor Town	State, Zir	Code)
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Tis marked other than "natural", or items 23a or 28a-f she rate work, the Medical Examiner must be notified at once the Doctor and the North Americal Director	2 1	9a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address (Stre 0 HWY . 1	et and Number o 19. Hira	m, KY 4	082	3	,, 0.0.0,	,
imore, MD 2121 Pages I and 2 should be finent of Health and Mental lant: If item 27 is marked or other traumates over	1	Amanda Sturgill,	wire	100-		osition (Name of ce		Date		. Location -	City or Tov	vn, State
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Baltimore, ME permit. Pages 1 and 2 st Department of Health a Important: If them 27 injury or other traum	1	1 Signature of Funeral Service Licens	ee MO	1113	22.	Name and Addres O Drawer	ss of Facility 1	nam. KY	408	07	1101110	
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Records, P.O. Box The law requires that the death icate has been signed by the arte page 2 should be detached for u	Completed								erforme 'es 2		1 Yes	2 No
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ital sician is cert	Be	examiner?	lospital: 1 Inpa	itient 2	ER/Outpati	ent 3 DOA	Other N	ursing Home 5		sidence 6		Scene
Division of Vital Records, P.O. Box 6876i pital or Attending Physician: The law requires that the death certificate ours after death. In a pital Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the b	6	1 Yes 2 No 27. Manner of Death	28a. Date of I (Month Da Apr 22, 200	njury	28b. Time		Injury at Work?	Driver at		injury occu to collisio		
nding th.	io	1 Natural 5 Pending		18 ^{' • • •}	0740 hrs	1	Yes 2 🗸 No					
isic Atter rector	Certification:	2 Accident Investigat 3 Suicide 6 Could not	28e. Place of	f Injury - At	home, farm, s	street, factory, office	ce building, etc.	T	··· Ctat	-1		al Route Number, City
Div	ertif	determine	d (Specify)	//ajor Ro	ad / Highv	vay		Route 1 r	near Pa	tuxent Kar		, Jessup, MD
E 5 5 4		20a Certifier	ian: To the best of	f my knowle	edge, death o	courred at the time	e, date and place	, and due to the	cause(s	s) and mann d place, and	er as stated due to the	d. cause(s)
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examine	r:On the basis of e and manner state	examination ed.	and/or inves							ith, Day, Year)
F. 2 E 2	Re	29b. Signature and title of certifier	1			1	ense number		- 1	April 23, 2		,,
9 h		1//	1 1				.C.M.E.			τριπ 20, 1		
OCME		30. Name and address of person who	completed cause	of death (Ite	em 23a)	444 E 21	and Daleton -	- MD 2420	1			
OOME		Mary G. Ripple MD. De	eputy Chief Me		_	111 Penn Str	eet, baitimor		'			
	tate	31. Date filed (Month, Day, Year) APR 2 8 20	08 32 Regis	strar's Sign	attre	ade						
Regis	trai	AFREDE	7		-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month. **Physician** 1537 2008 22 AUID /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner HOTPHE COLUMBIA orme If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birt 8. Date of Birth 5. Social Security Number **Funeral** Days Hours 1 M 2 F 07/29/1950 MD Director 214-56-932 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 No Director HOWARD COLUMBIA the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 6333 BRIGHT PLUME 21044 USA Items 23a (by Funeral Pages 1 and 2 should be filed within 72 hours after death in ent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or li edical Examin 1 ☐ Yes 2 💢 No WHITE Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) HOWARD COUNTY / than " ath and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS INSTRUCTIONAL ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS SHURKIN ELIZABETH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6333 BRIGHT PLUME, COLUMBIA, MD PEGGY HOCH / PARTNER item 27 i other tra 20b. Place of Disposition (Name of ARCHITCH CHIZUK AMUNO CONG. 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 04/25/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or complications that cause List only one cause on each 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final occordi **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner lans. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luz to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) aftending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 1No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To nours after death.

neral Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann of Death Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral I 8

Medical

29a. Certifier

(Check only one)

29b. Signature and title of cortifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ner stated

5755 CEDAR LANE, COLUMBIA, 21044

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0044763

29d. Date signed (Month, Day, Year)

22

2008

SALVADOR MARTINEZ, MD

			For America I tem State 26 per verb.	,g8 <u>78</u> ,	04/28/08	eath	iornai i iy	Reg. No. (2008	3 13702
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Mary L. Trexler				April		2008	1:30 P M
¢~	Examin	er	4a. Facility Name (If not institution, give street and number)	Ì	4b. City, Town, or I	Location of Death			County of Deat narles	tn
Maderia			11655 Doolittle Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. In	last hirthday)	Waldorf If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		thplace (State or Foreign
	Funeral Director		579-22-2701 1 M 2 M F 84 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	July 3	0, 19	923 Was	shington, D.C
	land ow			, Town or Loc	cation					10d. Inside City Limits
	Mary -f sh fied a	ţo	Maryland Prince Georges Upp	er Mar	1boro					1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Co	ountry?
	th wit	alD	15300 Nottingham Rd.		20772			U.S.A	Α.	
	ems erm	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Ame Black, Whit 	
020	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	I□Yes 21 No	Specify:			^{Specify:} Wh	ite
2 2	72 hc natu dical	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	lent's Usual Occupa kind of work done do OO NOT use retired)	tion uring most of work	ing	16b. Kin	d of Business	/Industry
Baitimore, Maryland 21215-0036	within jiene.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired) se Agent			Lend	ding In	stitution
g	0 = 0 4	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle	, Maiden S	Surname)	
Ja	2 should by and Menta is marked aumatic ev	TOE	Paul A. Moran			Louise	Mulliga	n .		
a	2 sho and I is ma	Ė	19a. Informant's Name/Relationship (Type. Print)		g Address (Street a					
Σ.	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		James Trexler/Son		Nottingh					
ore	0 0		MABURAL 2 LICERNATION 3 LINEMOVAL From State 1		sition (Name of natory or other place		Date		cation - City or	·
=	t. Pag tmen tant: ijury				1 Cemeter					laryland
g	permit. Pag Department Important: I any injury o		21. If nature 15 neral Service Liver Service Parties 9 (/ 6%	Name and Address					on, MD 20735
B	3		23a. Part 1. Enter the disease or complications that caused the death shock, or leart allyre. List only one cause on each line.	n. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Juse (Findisease of children resulting jurdeat")	~08	SA	f sea	fe.			Onset and Death
	/Medical Examiner		Due to (or as nsequ	uence of):						
	LAAIIIIIIei	<u></u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of the conditions)	ueneo of):						
/	ted sit	nine	cause. Enter Underlying Cause (Disease or injury	leffice of).						
χ̈́,	al-trai	Examiner	that initiated events resulting in death) Last c Due to (or as a consequ	uence of):						
200789	tificate be executed g physician and as the burial-transit		d							
9	± 00 €	edical			1147					
		M/m	IF FEMALE: 23b. Was decedent pregnant 1□ Live birth 2□ Fetal		Ectopic pregnancy			2	3d. Date of de	
מ כ	The law requires that the death celte has been signed by the attendinage 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de		Other (specify)				Month	Day Year
r Ö	at the I by th	J.	9 Li Unknown	10		- 1. B. 11	00- Pi-l			the server of death?
Š	v requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resu	nung in the ur	ndenying cause give	mmranı.				o the cause of death?
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Hecords,	e law has b	nple					24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
							1□ Yes	<u>δ</u> ΕΜο	1 ☐ Yes	s 2 No
VII	Attending Physician: r death. ector: After this certifice by the funeral director, p	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐	ED/Outration	othe	26. Place of Deat	1 -7		S S S S S S S S S S	Assisted
ō	Phys r this ral di	<u>ا۔</u>	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	f 28c. Injury	at Nursing Ho	28d. Describe			Living—
0	nding P th. : After i	ţi	1- Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work M 1 □ Y	:? /es 2 □ No				
DIVISION OF	l or Attend after death Director: /	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At he building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location	(Street and	d Number or Fi	Bural Route Number,
5		Certification:	building, etc. (opeur)	,			Ony or 10	, olale)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno and manner stated.	wledge, death tion and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) , date and	and manner a place, and du	s stated. le to the cause(s)
	Fo the within Fo the complex	Me	29b. Signature and title of certifier		29c. License	number		29d. Date	e signed (Mon	nth, Day, Year)
	A		+ Man -		D>.	£35.		4	11810	<i></i>
	10		30. Name and address of person who completed cause of death (Item	n 23a) (Type,	Print)	1	^ ^ !	\ -	11.	/
_	\		40 BOX 272	7/	Print) CP	(6/2	10	20	064	6
	Sta		31. Date filed (Month, Day, Year)	ture						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11,2008 Lemus Amaya De Los Angeles April 12:15a [™] 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Days Hours 8972 44 1983 E1ºººsalvador 1 □ M 2 🔀 F 24 none Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Silver Spring 1 ☐ Yes 2X No Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number El Salvador 20903 341 Southampton Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced El Salvador 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Julia Amaya Jose Lucas Lemus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090319a. Informant's Name/Relationship (Type. Print) 341 Southampton Drive Silver Spring, Md Carlos Alfredo Calles/Friend 20b. Place of Disposition (Name of cemetery, crematory ocother place)
Cemeterio de 20c. Location - City or Town, State
Gualdtectic Cabanas, Date 20a. Method of Disposition 4/16/2008 Salvador Gualdtectic Cabanas BHYTTPA MOSS TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signature of neral Service Lice 23a. Part1. Enter the Asease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Mitral Regurgitation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 ₹ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner**

certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Physician

/Medical

Examiner

MD

Funeral

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

Medical

l other than " vent, the Mer

nd 2 should be filed lith and Mental Hygi 27 is marked other r traumatic event, ti

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.

Director

Funeral

Completed by

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examine and Il-transit physician a the burial-Physician/Medical as attending properties for use as sate has been signed by the a page 2 should be detached ð Completed Be

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Certification:

Medical

the

by

certificate

this

funeral

To the Hospital or Attending Pru within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 X Natural

2 ☐ Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H0064588

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd.Silver Spring, Md 20910 Tolia D.O. Ashish

1 🌠 Inpatient

28a. Date of Injury (Month, Day Year)

State Registrar 32. Registrar's Signature



2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

			For State	State of Mary		partment of F			iene _{eg. No.} 2 () (08	13704
REF			Registrar 1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	th		3. Time of Death
	Physicia		ALPHONSO	ALSTON	JR.			APRIL		Year 008	12:30 P M
	/Medic Examin	100	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1	4c. County o		
			CLINTON NURSING	G HOME		CLINTO			PRINC		ORGE'S
	Funeral		Social Security Number 6. Security Number	TM 2DF	yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	Cour	
	Director		220-78-5817	47				JULY 2	1960	WASH	INGTON, DC
	and w	ł	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				1	0d. Inside City Limits
	Mary f sho	to	MD PRINCE (GEORGE'S	DISTRI	CT HEIGHTS	3				1 XYes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Cour	ntry?
	th wit		8730 RITCHBORO I	ROAD		2074			USA		
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		- Amerio , White,	ean Indian, etc.
92	after, or it	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify:	BL	ACK
5-0036	hours tural' al Ex	q pe	15. Decedent's Ed	Year or Dates:	16a. De	ecedent's Usual Occup	ation		16b. Kind of Bus	siness/In	dustry
215	in 72 n "na Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(G lit	ive kind of work done e. DO NOT use retired	during most of world)	rking			
212	d with giene rr thai	mo	12th	College (1-401 54)		COMPUTER O	PERATOR		PR	IVAI	E
Maryland 21	uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show attic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, i	Maiden Surname	9)	
<u>X</u>	should b and Ment marked umatic e	은	ALPHONSO ALSTON					A HAILE			
Jar			19a. Informant's Name/Relationship (* JUANITA ALSTON/			ailing Address (Street					
	1 and 2 Health tem 27 I		20a. Method of Disposition		Ob. Place of Di	4 COLUMBIA sposition (Name of			MAKY LA 20c. Location -		
وّ	0 0 - 1		1 □ Burial 2 □ Cremation 3 □	Removal from State	cemetery,	crematory or other pla RECTION CE	_{сө)} ; метеку 4	/19/2008	CLINTON	.MAF	RYLAND
altimore,			4 □ Donation 5 □ Other (Specifical Service Licer		KEDUK	22. Name and Addre	1	J B JE			
Ba	permit. Departr Importa any Inj		> // MAR 3/	10 delias		7474 LANI	OOVER ROA	AD LANDOV	ER, MARY	LAND	20785
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not	enter the mode of dyin	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CAMOW 1	ovemon	ANT ARE	LEST				Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of):						
B	Examiner	Į,	Sequentially list conditions,	b. Due to (or as a co						_	
	ed sit	nine	cause. Enter Underlying Cause (Disease or injury	HIV A							
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8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			d							
9	tificati g phy as the	Physician/Medical									
Вох	th cer endin	an/Iv	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p		3 ☐Ectopic pregnanc	у		23d. Date Mor		ery Day Year
	res that the death certific igned by the attending p be detached for use as	sicia	in the past 12 months? 1 □ Yes 2 □ Vo 9 □ Unknown	4☐Pregnant at tim 9☐Unknown	e of death	5 ☐ Other (specify) _			INIO	1611	Day Tour
P.0	hat the d by t letach	Phy	Part II. Other significant conditions	contributing to death but n	ot resulting in th	ne underlying cause giv	ven in Part I.	23e. Did to	bacco use contr	ibute to	the cause of death?
ds,	signe d be c	l by	END STAGE MINA					1 🗆 Y	'es 2□ No	3 ☐ Pro	bably 4 Munknown
200	w require been signature	Completed	HTPRITRUSION	,				24a. Was a	an 24b. V	Vere aut	opsy findings available
æ	he lav e has age 2 a	dwo	11 11 helico more					autop perfo	rmed2 c	orior to co leath? □Yes	ompletion of cause of
tal	iclan: Th certificate ector, pag		25. Was case referred to medical				26. Place of De	ath (Check only o		Lies	20110
>	Physicia this cer af direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Ott	ner: 4 Nursing	Home 5 ☐ Resid	lence 6 Goth	er (Spec	ify)
Division or Vital Records,	Attending Physician: The lar death. ector: After this certificate he by the funeral director, page		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Tin ear) Inju		ry at rk?	28d. Describe h	ow injury occurr	ed	
<u>Si</u>	endir eath. or: Ai	atic	2 ☐ Accident investigation				Yes 2 No				
Ë.	or Att fter de Direct in by	Certification:	3 Suicide 6 Could not b 4 Homicide determined		- At home, farm Specify)	i, street, factory, office		City or Tou		er or Hui	al Route Number,
	pital		29a. Certifier 1 ertifying PI	nysician: To the best of n	nv knowledae.	death occurred at the t	ime, date and plac	ce, and due to the	cause(s) and ma	inner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis of ex and manner stated	amination and/	or investigation, in my	opinion, death occ	curred at the time,	date and place,	and due	to the cause(s)
	To the Vithin To the Comple	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed		
				0-	cu,	0006.	036		04/12	122	8
0	(5)		30. Name and a ress of person who	completed cause of deet	h (Item 23a) (T	ype, Print)	E IIA CITTI	отом во	20010	601	ween or
1			YUDH GUPTA M.D.		0: 1		O WASHIN	GION, DC	20010//	MAN	Less here
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 5 2008	32. Registrar's	Signature	,					
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene UUU

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Howard Spencer Brasted, Jr. 11:05 P.M April 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville National Lutheran Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 7, 7. Age (In vrs. last birthday) **Funeral** Days ^{Year)} 1922 1**X** M 2□ F Hours New York 096-12-0354 A 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Mudical Exertment by Italified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Rockville 1 Yes 2 No Montgomery Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive United States 20850 Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Amed Forces:

12 Yes 2 No.
1942-1946 1 Never Married 2 Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Health Scientist 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Spencer Brasted Gladys Viola Ronald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9303 A Wescott Place, Rockville, MD 20850 Elaine J. Brasted/Wife April 2008 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University MedicalCenter 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licenses 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown þ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has certificate 1 Yes 2 1 No 2 No 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 4 Hursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA SIU After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t Detural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and little of certifie 29c. License number Date signed (Month, Day, Year) Cenen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, M.D. 31. Date filed (Month, Day, 32. Registrar's Signature State 4

DHMH 17 Rev 1/2001

Registrar

State Registrar 30. Name

31. Date filed (Month Day,

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Régistrar's Signature

and address of person who completed cause of death (Item 28a) (Type, Print)

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MD 7600 Carroll Ava. Takomfork

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 Month 12:10p Lorraine Barnes April 13, Catherine 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Hospice-Casey House
5. Social Security Number 6. Sex 7. Age (In yrs. Rock villa

If Under 1 Year 1 Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Montgomery Birthplace (State or Foreign (In yrs. last birthday, 1 □ M 21K F 219-12-4697 83 Sept. 1924 Washington, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 11706 Eden Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2CXNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth I. Briscoe William H. Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Ernest Gray Barnes/Husband 11706 Eden Road, Silver Spring, MD 20904 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 16, 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Carmel Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Sunshine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Cancer

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner

	resulting in death)	Due to (or as a conseq	uence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	uence of):				
	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	al death 3 ☐ Ectopic pr			23d. Date of delivery Month Day	Year
	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying c	ause given in Part I.		use contribute to the caus	
					24a. Was an autopsy performed? 1 Yes 2 X N	24b. Were autopsy find prior to completion death? 1 □ Yes 2 □ No	
)	25. Was case referred to medical			26. Place of De	ath (Check only one)		
)	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3 □ DC	DA Other: 4 Nursing H	Home 5 ☐ Residence	6 Denther (SpecifyHos	pice
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how inju	ury occurred	
	3 Suicide 6 Could not b 4 Homicide determined		iome, farm, street, factor	y, office	28f. Location (Street a City or Town, State	nd Number or Rural Route le)	Number,
200	29a. Certifier Check only 2 Medical Example (Check only one)	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the ca	iuse(s)
5	29b. Signature and title of certifier	1. 10	(29	c. License number	29d. D	ate signed (Month, Day, Y	ear)

State Registrar Genevieve Wroblewski, MD istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road, Rockville, MD 20855

April 13, 2008

n 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Stanley Brooks 2:18 M 04 2008 Apri /Medical 4c. County of Death 4a/Facility Name (If not institution (give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 1 Birthplace (State or Foreign Country) **Funeral** 1**)**(N) 2□ F 219-18-3504 83 Maryland 1924 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 27 No Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Wellham Avenue 21061 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or ite any or other traumatic event, the Medical Examinee my or other traumatic event, the Medical Examinee. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ KNo Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th 0 Truck Business Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Randolph Wesley Brooks Mazie Corine Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Mack (Daughter) 1411 Flagstone Ct. Severn, Md. 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Calvary Cem 4-11-08 Baltimore, Md. Manname Rocks of Gacilicons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 any & Beese MOGY8 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deal Immediate Cause (Final disease or condition resulting in death) neumonia Physician /Medical Due to (or as a onsequence of): Examiner hron; c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown has been si e 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

ves 2 No certificate ha 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008

State Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Pylistrar's Signature

Medical

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State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 1, Decedent's Name (First, Middle, Last) Physician MARCH **2008** 4:10PM ^M LOUIS L. BOLDT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT EASTON 7566 17TH DRIVE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Months Min. 1**X** M 2□ F MAR 20, 1922 86 ILLINOIS Director 354-07-0100 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show e notified at 10a. State 10b. County Yes 2 □ No TALBOT EASTON Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be r USA 7566 17TH DRIVE 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 😿 No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION SUPPLY 4 OWNER/PRESIDENT 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be MINNIE B. VEGTER ပ LOUIS A. BOLDT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7566 17TH DRIVE, EASTON, MD 21601 of Health NANCY BOLDT/WIFE other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If Ite
any injury or of
once, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 3/29/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph Estrounh 31. 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SESTIVE CON disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** 91 Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. physician use as t IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 res 2□ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 perform 2. No certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After: Injury 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Directory filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. 29a. Certifier Medical (Check only 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 80+VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J/EGLSEDER III M.D. 503 CYNWOOD DR., EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. gistrar's Signature State MAR 2 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 4:42 AM LEGNARD BONGERS q 2008 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb 5, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 MM 2 □ F Netherlands Director 212-42-1967 83 Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City. Town or Location 10a State 10b. County 10d, Inside City Limits Westminster Carroll 1 XYes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural", or items 23a or dical Examiner must be r 21158 11 Fannies Meadow Court USA by Funeral death 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3s 1 and 2 snours of Health and Mental Hygiene.
of Health and Mental Hygiene.
If item 27 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Environment Scientist 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelmina Ophey Lambertus Bongers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Fannies Meadow Court, Westminster, MD 21158 Hermine Bongers, wife Date 20b. Place of Disposition (Name of Semateria crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of IImportant: If ite
any injury or ot
once, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Winfield, MD 4/12/2008 Carroll Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Sease Licen-91 Willis Street, Westminster, MD 21157 hari 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** MYOCARDIAL INFARCTION 24 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760, death certificate be Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a I□Yes 2□No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>\$</u> be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an page 2 s autopsy performed' 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBurness MEDICAL DOCTOR RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONIKA BURNESS, THE JOHNS HOPKINS HOSPITAL, GOD NORTH WOLFE STREET, BALTIMORE, MARYLAND 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elseva APR 1 1 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Marie Bowman 2008 April 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4711 Berwyn House Road College Park

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Prince George's 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 218-24-2988 1 □ M 2 🛛 F 83 Director 2-13-1925 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; if Item 27 Is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits Prince George's YYes 2 □ No Director MD College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4711 Berwyn House Road 20740 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give¹ Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes Z No Specify: Baltimore, Maryland 21215-0036 3√2 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Hostess 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Williams Minnie Arehart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
37665 B Locks Crossing Boad
Mechanicsville, MD 20859 Constance Gainey- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/14/2008 Brentwood.MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Brentwood, MD 20772 when monte it 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 10 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation To the nospie...
within 24 hours after death.
To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 063127 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

CR 4

E. Pasmanik, M.D.

State
Registrar

E. Pasmanik, M.D.

APR 1 5 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

14205 Park Center Drive Suite 202 Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			for State Registrar	0.0.0	,	Certi	ficate of L	Death		,	Reg. No.	201	10	101	10
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		ш	103 Kerby Hill Ro	l			Fort Was	_				ince (
	Funeral Director		5. Social Security Number 6.	Sex 7. Age 11 M 2 F 57	(In yrs. last birt		f Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	B. Date of Bir (Month, Da March	th ly, Year) 11,19	9. ∂51 C	Birthpla Country ONNE	ce (State or F () Cticut	oreign
	TO		Usual Residence of Decedent										100	I. Inside City I	Limite
	how lat	_	10a. State 10b. County		10c. City, Towr								100	1 ☐ Yes 2	
	e Ma sa-f s	cto	Maryland Prince (George	Fort \		ington						10: 1		41
	or 28	Director	10e. Street and Number				10f. Zip Code	,				zen of Wha USA	at Countr	y?	
	ath w	ral	103 Kerby Hill Ro			10.14	20744		:-:-0 (0	if . Van an Na		14. Race -	America	Indian	
	tems	Funeral	11. Marital Status	12. Was Decedent E		13. Wa	s Decedent of Hi es, specify Cuba	n, Mexica	n, Puerto R	tican, etc.)		Black,	White, et	c.	
2	s afte		1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 📉 No If Yes, Give Year or Dates:)	1 🗆]Yes 2. No	Specify:				Specify:	Whit	.e	
2-0030	filed within 72 hours after death with the Maryland Hyglene. Ither than "natural", or items 23a or 28a-f show ther, the Medical Examiner must be notified at	Completed by	15. Decedent's 8	Education	16a.	Deceder	nt's Usual Occupa	ation			16b. Kir	nd of Busin	ness/Indu	stry	
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yland	uld b Ment arked atic e	To	George Boisse					Mar		arnica					
Mar	2 sho and Is ma		19a. Informant's Name/Relationship			_	Address (Street								
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0	ges 1 if of H if Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐Removal from State	Kalas	rv. crema	tory or other plac		4-14-		1		•	lary1an	ıd
Банттог	t. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Liç		1.0		Name and Addres	!							
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Fulleral Service Lic	las A			O Oxon I			_					
r			23a. Part. Enter the disease, or co	mplications that caused	the death. Do	not enter	the mode of dyin	g, such as	s cardiac o	r respiratory	arrest,			Approximate Interval Betwe	en.
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Sic	Attending Physician; r death. ector: After this certific by the funeral director,	icat	2 Accident investigat 3 Suicide 6 Could not	be 280 Place of inju	ry - At home, fa	arm, stree		700 2		28f. Location	(Street an	nd Number	r or Rurai	Route Numb	oer,
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	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledg	je, death	occurred at the ti	me, date a	and place,	and due to th	e cause(s) and man	ner as st	ated.	
	ne Ho n 24 l ne Fu	Medical	(Check only 2 Medical Ex	caminer: On the basis of and manner sta	examination a ted.	na/or inve				ou at the time					
	To the within 2 To the comple	ž	29b. Signature and title of certifie	11111			29c. Licens			,	29d. Da	ite signed			
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	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 5 2008	Been D	ar's Signature	20									

Division or Vital Records, P.O. Box 68760,	Baltimore, Maryland 2	Ò
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Losual 10a. S 329 11. Ma 1	3 16 68 I Residence of State C. Street and Nu	353 f Decedent		4a. Facility Name (If not institution, give street and number) St. Thomas Moore Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						4c. County of Death Prince Georges of Birth 9. Birthplace (State or Fore			roian	
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o 17. Famo 17. Famo 17. Famo 19. I 19a. I 19	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVER 16b. Kind of Business/Ir						·	ste		
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Seque if any cause Cause	Part1. Enter t shock, or hea ediate Cause ase or conditio Iting in death)	on	y one cause on e	caused the deatleach line. ONIC OBS (or as a consequence)	TRUCTI				respiratory a	rrest,		Approximate Interval Betwee Onset and Deat YEARS		
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ex 0 1[27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year)					26. Place of Death (Check only one) R/Outpatient 3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □Other (Spec 28b. Time of Injury M 1 □ Yes 2 □ No 28d. Describe how injury occurred						cify)		
Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, streeth building, etc. (Specify)						City or 1				n (Street and Number or Rural Route Number, Town, State)			
edice	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											e to the cause(s)		
29b. S	29b. Signature and title of certifier Rucklandlung						29c. License number D01852				29d. Date signed (Month, Day, Year) APril 14, 2007			
30. Na	1	an Cl	inle	1 h		D01	852			APr	il 14,	2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P^{M} 10, Margaret May Beall 2008 9:47 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) 9/24/1942 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 TF Months i Days Hours Min. 65 Washington D.C. Director 579–56–1592 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside Cify Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 USA 15408 Marlboro Pike Funeral 14. Race - Americen Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛂 No altimore, Maryland 21215-0036 Specify. þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other 1 any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beaulla Catteron John Carver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Leroy Beall/Spouse 15408 Marlboro Pk. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 4/16/2008 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYDCARDIAL TNEARCHON /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any harmy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as t as been signed by the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1□Live birth 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? Yes has page this certificate 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 Inpatient 2 NOutpatient 3□ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Matural 2 Accident 5 Pending Injury To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50689. no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MAI+ATAN-MA-7503 SURRATIS 20 CLINTUN in 20735 COUTHERN MARYL HUPDITAL CE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State amend #2 per Phy 98/8 4/28/08 Certificate of Death

Reg. No. 2 2. Date of Death Apr. 10, 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:00p April 2008 Douglas G. Coffman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5507 Cordona St. Lanham Prince Georges Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 27 Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min 1**√** M 2□ F 212-68-3342 51 1956 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b County 10a State 1∏Yes 2∏No "natural", or items 23a or 28a-f show alical Examiner must be notified at Lanham Director Maryland | Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examinat Derivance. 5507 Cordona St. 20706 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Edcondary (0-12) College (1-4or 5+) Retail Clerk Liquor City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
George G. Coffman Sr. Be Ruth Fenton Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5507 Cordona St. Lanham. MD 20706 Ruth F. Coffman (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/08 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Approximate Interval Between Onset and Death P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Nonsmall Cell Lundances 3 months mediate Cause (Final metastat.c **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural ours after death. ieral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4/12/2008 D50686 MD

State Registrar 31. Date filed (Month, Day, Year) 4 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6510 Kenlwoth Avenue Riverdale MD-

08-02641 Jermaine Chambers	State of manytanes a special services	egible. 2008 371
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of De	Day Year 4000 h
Medical Examiner	Jermaine T. Chambers 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
£*	Prince George's Hospital Cheverly	Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8 Months Davs Hours Min.	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign New Jerse)
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	MD Prince Georges Clinton	1 X Yes 2 No
tth the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
th the 23a or notifical Di		USA No- 14. Race - American Indian, Black,
or items 23	11. Marital Status 12. Was Decedent Verified 1.S. Was Deceded 1.S. Was Decedent Verified 1.S. Was Dec	White, etc.
fler de	1 3 Windwed 4 Divorced III 168, Give 1641 [] 165 2 V NO Specify.	Specify: Black
ours aft attiral?		16b. Kind of Business/Industry
6 n 72 h an "n ical E	Elementary/Secondary (0-12) College (1-4 or 5+)	Designation
5-0036 led within 72 hour Hygiene. other than "natu the Madical Exar Completed	10th Bricklayer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle)	Privatee, Maiden Surname)
1215-0036 Id be filed within 72 dental Hygiene. narked other than event, the Medical ob Be Comple	Jefferson Chambers Celia Car	mpbell
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		lumber, City or Town, State, Zip Code)
Fe, No. 1 and Health	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	20c. Location - City or Town, State
Pages ment of tant: If	Fort Lincoln Cem. 4/12/08	
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin	-
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory	Nashington, DC 20011
Physician Medical Sxaminer	failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds	Between Onset and Death
•	or condition resulting in death) Due to (or as a consequence of):	
4	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ed nsit	Course Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
and ecut	0	
Records, P.O. Box 68760, The law requires that the death certificate be excate has been signed by the attending physician page 2 should be detached for use as the burial committed by Physician/Medice.	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
687 extifice ding pl	23b. Was decedent pregnant in the past 12 months?	Month Day Year
OX (eath or attent for use	4 Pregnant at time of death 5 Other (Specify)	
O. B. trihe de by the ached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Di	id tobacco use contribute to the cause of death?
P. P. Cres that signed be det		Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been signated as 2 should be	24a. W au	/as an 24b. Were autopsy findings available prior to completion of cause of
eco he law ite has	1 ✓ Yo	erformed? death? es 2 No 1 Yes 2 No
an: T	b 25. Was case referred to medical 26. Place of Death (Crieck Only One)	
Vita hysicia this ce	1 Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA 4 Nursing Home 5	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial confined Certification: To Be Completed by Physician/Medice		ibe how injury occurred hot
Division Division 1 lospital or Attend 24 houst after death Finneral Director: etely filled in by the I	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location or Town	on (Street and Number or Rural Route Number, City
Spital hours neral		apeake Street # 103 , Washington , DC
To the 11a within 24 To the Fu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the concern of the	late and place, and due to the cause(s)
To the within To the comple	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
5	Don min who o.C.M.E.	April 4, 2008
	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat	e 31. Date filed (Month Dr.), Year) 4 2008 32. Redistrar's Signature	
Registra	ar parties of the same of the	

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** 7:50 a M Mariorie Mae Clary 05 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehabilitation Center Montgomery Kensington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days Min 1 □ M 2 🕱 F Pennsylvania 87 March 8, 1921 Director 183-18-0899 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10804 New Hampshire Avenue 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 XWidowed 4 ☐ Divorced White WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Johns Hopkins University Elementary/Secondary (0-12) College (1-4or 5+) Applied Physics Lab 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event Be Flossie Walz Samuel D. Delp P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton O. Vann - Friend 330 Taylor Street, NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Fort Lincoln Crematory 04/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Ò 21. Signature of Funeral Service Licent 22 Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi le Cause (Final disease or condition **Physician** Coronary Artery Disease Years resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ischemic Cardiomyopathy Years Sequentially list conditions, it and it immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed as the burial-transil and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IE EEMALE asn If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Year in the past 12 months? Day 5 ☐ Other (specify) P.O. I ed by the a detached for I Ves 2 No 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Nunknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has ral director, page 2: 1 TYes 2 X No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1 XNatural 5 ☐ Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895 31. Date filed (Month Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylar	•	rtificate of			Reg. No.2 0 0	8 37 9
	Dhysisis		Decedent's Name (First, Middle, Last	0				2. Date of Dea Month		3. Time of Death
	Physicia /Medic	al		allejas			- I I I D N	April	05, 2008 4c. County of	
	Examin	er	4a. Facility Name (If not institution, give Holy Cross Hospi			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	r Location of Deat Spring	n		gomery
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days			h y Year)	Birthplace (State or Foreign Country)
	Director		None	X M 2□F	0 Yrs.	Months Days	Hours 5	Apr. 05		Maryland
	and *	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	f sho	ō	Maryland Montgom	norw F	lockvi1	10				1 ☐ Yes 2 🛣 No
	the 28a-	Director	10e. Street and Number	ery n	COCKVII	10f. Zip Code			10g. Citizen of Wha	at Country?
	h with	al D	13808 Bauer Driv	е		2085	3		Unite	ed States
	ems :	Funeral I	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	. 14. Race - Black,	American Indian, White, etc.
2	or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give		1X Yes 2□ No	Specify:		Specify:	Val.
Ś	hours tural'	q pa	15. Decedent's Edi	Year or Dates:	16a, Dece	dent's Usual Occup	ation	Salvador	16b. Kind of Busin	other ness/Industry
2	in 72 n "na Medic	plet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo d)	rking		·
7	d with giene grene rr tha	Completed	0	College (1-401 5+)	No	ne			Non	ne
2	be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	
<u>x</u>	ould to	ဥ		allejas	101 11		Brenda		Zavala	7-0-41
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I mimortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7						er, City or Town, Sta	ate, 2/p Code)
ב ע	1 an Heali tem 2		Brenda M. Calleja: 20a. Method of Disposition	20b.	Place of Disno	sition (Name of		Date	MD 20853 20c. Location - Cit	ty or Town, State
5	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		matory or other place		/11/2008	Silver	Spring, MD
Daltillo	mit. F partm sortar / Inju		21. Signature of Funeral Service Licen			2. Name and Addre		Simple T		bpring, in
Ŏ	permit Depar Impor any Ir		My	\rightarrow					ille,MD 2	
			23a. Part1. Enter the disease, or composhock, of leart failure. List only	plications that caused the dea one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	ľ	Immediate Guse (Final disease or condition resulting in death)	a Severe hydro	_					29 weeks
	/Medical Examiner		recording in deathy	Due to (or as a conse		cardino.	dianaan			29 weeks
		ē	Sequentially list conditions,	b. Severe congo		cardiac	uisease			29 Weeks
	cuted id ansit	Examiner	Sequentially list conditions, it is a second conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	C						
5	e exec ian an urial-tı	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
00/00	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		.d						
X	certifi Iding I	-	IF FEMALE:	23c. If yes, outcome pf pregi	nancy				23d. Date (of delivery
200	death a atter	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		□Ectopic pregnanc □ Other <i>(specify)</i> _	У		Month	
į	t the o	hysi	9 🗆 Unknown	9□Unknown						
, L	es tha gned be del	by P	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.			ute to the cause of death?
ecolus,	requir een si ould	Completed								
ב ב	elaw hasb je2sl	mple						24a. Was auto	psy pri	ere autopsy findings available or to completion of cause of ath?
2	n: Th ficate r, pag		OF Management and the manifest				00 Pl 4 P -	1□ Yes	2 ☑ No 1 L	Yes 2 No
VICA	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2[☐ ER/Outpatie	nt 3 DOA Oth	nor:	eath <i>(Check only o</i> Home 5 ☐ Resi	idence 6 □Other	(Specify)
0 10	g Phy ter this neral o	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	1	how injury occurred	
200	endin ath. or: Aff he fur	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation				Yes 2 No			and the second second
<u> </u>	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, st c <i>ify)</i>	reet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
ב	pital (ours al eral E		29a. Certifier 1 Certifying Ph	ysician: To the best of my ki	nowledge, dea	th occurred at the t	ime, date and place	ce, and due to the	cause(s) and man	ner as stated.
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Within 24 hours after death. To the tuneral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Medical	(Check only 2 Medical Exam	niner: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my	opinion, death occ	curred at the time	, date and place, an	nd due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen:		-	29d. Date signed (
) (Seors	2		00	0 5551	>	04/06	1008
		1	30 Name and address of person who	completed source of death (It	om (12a) /Tupo	Drint\				

Andrea Lotze, M.D.

1500 Forest Glen Road, Silver Spring, MD 20910
32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

	1	r	1- State of Maryl State of Maryl		artment of H rtificate of L			ene g. No. 2 ()	08	13720				
25	D.		Decedent's Name (First, Middle, Last)				2. Date of Death		Year	3. Time of Death				
	Physicia Medic		Albert Cread Jefferso	n Calaway			April	09	2008	7:20 p ^M				
)	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County		mora/				
	Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	er Spring If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign				
	Director		279-34-9363 ¹ ⊠M 2□F 7	4 Yrs.	Months Days	Hours Min.	July 4,		Count	Ohio				
	and w		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation	-	-		10	Od. Inside City Limits				
	Maryle f shor	ō	Maryland Montgomery	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		lver Sprin	g			1 □Yes 2 No				
	r 28a-	Directo	10e. Street and Number		10f. Zip Code	•		g. Citizen of	What Count	try?				
	th with	al D	2417 Hidden Valley Lane			20904			U.S.A	•				
	filed within 72 hours after death with the Maryland Hygene. ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13. V	Was Decedent of Hi If Yes, specity Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e					
0030	irs afte	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Kore	an War	1 ☐ Yes 2 ⊠ No	Specify:		Specif	y:	White				
5	2 hou natura ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation	ring 1	l 6b. Kind of B						
7	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired) -	ang							
7	led will her th	ပွဲ	17. Father's Name (<i>First, Middle, Last</i>)		Denti		e (First, Middle, M			care Service				
alla	d be fi	Be C	Cread Campbell Calaway				Marquerite		,					
	shoul ind Me ind Me inari	욘	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street a					Code)				
, K	and 2 salth a 27 is er trai		Susan Calaway Jacques - Daughter											
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □Cremation 3 Removal from State	b. Place of Dispos cemetery, cren	sition (Name of matory or other plac	e)	Date 2	20c. Location	City or To	vn, State				
partituor	t. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)		ve Cemetery		4/2008	Cincinna	ti, Oh	io				
0	perm Depa Impo any i		21. Signature of Funeral Service Licens, e	· H	2. Name and Addres Lines-Rinal LIRON New Ha	li Funeral	Home, Inc.	er Sorin	o Mar	yland 20904				
h			23a. Part1. Enter the disease, or complications that caused the c shock, or bean failure. List only one cause on each line.						, ini.	Approximate Interval Between				
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Solds	requir een si nould l						1 ☐ Ye	Yes 2 No 3 Probably 4 Unknown						
S S	ne law has b je 2 sh	Completed					24a. Was an autopsy	y	prior to con	osy findings available npletion of cause of				
<u></u>							perform 1□ Yes 2	No No	death? 1 ☐ Yes	2□ No				
	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient	2 ☐ ER/Outpatien	ot 3 DOA Othe	or.	th <i>(Check only one</i> ome 5 Reside		or (Coosifi	4				
5	ding Physician: The lav n. After this certificate has funeral director, page 2	—	27. Manner of Death 28a. Date of Injury	28b. Time of			28d. Describe ho			,				
SION	endin sath. or: Af he fur	atio	2 Accident investigation	.,		Yes 2 □ No								
Ž	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (Str. City or Town,	reet and Numi , State)	ber or Rurai	Route Number,				
_1	spital ours a neral i		29a. Certifier 1 ☑ Certifying Physician: To the best of my	knowledge, death	h occurred at the tin	ne. date and place	and due to the ca	ause(s) and m	anner as st	ated.				
	To the Hospital or Attending Physician: which 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.											
	To th To th COTT	M	29b. Signature and title of certifier	Do	29c. License			d. Date signe						
	1.		Mull Joha	10	H	00 6 4 5	88	4-1	1-2	008				
	9		30. Name and address of person who completed cause of death (Ashish Tolia, D.O., 1500 Forest		· ·	oring Mary	Arone back							
	Sta	ite	21 Data filed (Month Day Vear) 32 Reflistrar's S		i, priver 9	ring, mary	14IIU 2U7IU							
	Registr		APR 14 2008	18 1	30046									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day April 17:15 PM Lon Duncan Campbell 0. 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cecil Calvert Manor Healthcare Center Rising Sun rear If Under 24 Hrs. 8. Date of Birth
avs Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Days 218-46-3276 March 18,1947 | Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🙀 No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1511 Elk Forest Road 21921 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status tytyes 2□No If Yes, Give US Army Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2√XNo Specify:White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supervisory Adjustment Counseling Team Leader 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ronda Jones Campbell Eva Irene Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clara Campbell / Sister 103 Court House Plaza, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2008 North east, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Euner Servi 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days MIMONARY disease or condition resulting in death) Due to (or as a consequence of): Cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a dessequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Important: If It any injury or c

Physician

/Medical

Éxaminer

Director

Completed by Funeral

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

al Hygiene.

and Mental

72 hours after death with the Maryland

Pages 1 and 2 should be filed within

21215-0036

Baltimore, Maryland

the death certificate be executed attending physician and for use as the bunal-trar

signed by the a Id be detached f peen cate has b page 2 s After this certificate funeral director,

Box 68760. P.0. Records, Division or Vital Physician: or Attending within 24 hours after death.

To the Funeral Director: / Hospital

12+1VA

State Registrar

filled in by the

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient ပို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1002832-1

29c. License number

29d. Date signed (Month, Day, Year)

Way, Rising Sun, MD COLONIAL LATTIN,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Clark Month O4 Year Physician Newton Gayland 3 3002 08:26A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 115 E MAIN ST. SUDLERSVILLE QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 220-28-1852 /25/1931 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director QUEEN ANNE'S SUDLERSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 115 E MAIN ST. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAB TECHNICIAN FOOD PRODUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VERNON CLARK NETTIE BAKER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREG CLARK/SON PO BOX 237 SUDLERSVILLE, MD 21668 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 4/18/2008 SUDLERSVILLE, MD SUDLERSVILLE CEMETERY FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 WEST CYPRESS ST. MILLINGTON, MD 21651 21. Signature of Funeral Service License uf Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Chronic Obstructive Lung O years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular Disonso Ostooperosis 14 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 27 Manner of Death 28d. Describe how injury occurred

Examiner burial-tran physician the as ed by the attending detached for use as cate has been signed by page 2 should be detact

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death v

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or #*~~ any Injury or other traumatic event ***.

Physician

/Medical

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

15

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Bea

Stoldend 12-1

ar's Signature

St. Clestertown

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9^{ay}2008 Year **Physician** MORTH 3:20 A CHAVIS RUBY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES 2005 RUATAN STREET ADELPHI 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Months 1□M 2¬F 77 Yrs Director 227-40-8962 MARCH 6 1931 VIRGINIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1XYes 2 □ No Directo MD PRINCE GEORGE'S ADELPHI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Examiner must be no once. 20783 USA 2005 RUATAN STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No BLACK Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 10th FOOD SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREW FALTZ ALICE GREEN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHAVIS/NEPHEW 6705 GREEN MOSS DRIVE UPPER MARLBORO, MARYLAND 20772 JAMES 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 4/15/2008 BRENTWOOD, MARYLAND 4 ☐Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIABETES MELLITUS /Medical Due to (or as a consequence of) Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans CORONARY ARTERY DISEASE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√□ No HEPATITIS C 24a. Was an autopsy performed? 1□ Yes 2□No CHRONIC LIVER DISEASE Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 XNo Hospital: 5 Aesidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 10, 2008 D03835

State Registrar DAVID K. CROMWELL M.D. 831 UNIVERSITY BLVD E # 37 SILVER SPRING, MARYLAND 20903 32. Registrar's Sign sture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ADR 1 5 2008

APR 15

1 - For Steta Registrar State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Day **09** 3:50 pM Harriet Venable Davison April 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 927 Venice Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K F Min Yrs. Director 185-28-9133 July 17, 1933 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location or 28e-f show 10d. Inside City Limits itam 27 is marked othar than "natural", or Itams 23e or 28e-f show other traumatic evant, the Madical Examinating at Directo 1 Tyes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 927 Venice Drive 20904 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or her any injury or other traumetr. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Scott Venable 2 Olive Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 North Queens Lane, #194, Arlington, Virginia 22201 Keith B. Davison - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State ⁴ □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 04/15/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Abdominal Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þe 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 🗙 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 ☐ Accident 5 Pending Injury after death. investigation 1 Tyes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide a Funarel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) of death (Item 23a) (Type, Pring Name and address of person who completed cause G-100, Rockvil

Registrar DHIVIH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 **Physician** 06 2008 12:15A M Marion Gohl Decker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care Potomac Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 04/30/1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗐 F 96 Michigan 577 86 6377 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Montgomery Germantown Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 14710 Springfield Road 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (3-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Alice Gohl Herman Emil Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14710 Springfield Rd/Germantown MD 20874 Donald Decker (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 Removal from State Arlington Nat'l Cemetery 5/27/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services Annapolis MD and Falls Church VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Tes 2 No 3 Probably 4 No Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an page 2 s nas autopsy performed? certificate | 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide LESCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Creorgia Avance #1-17, Silverspring MD2090 Bhogavilla Sunitha 9801 31. Date filed (Month, Day, Year) State APR 0 9 2008 Registrar

DHMH 17 Rev 1/2001

State of Manyland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		tificate of l			eg. No.) 8	13/26	
٢	Physicia	an	1. Decedent's Name (First, Middle, Las	ot)				Date of Deat Month	Day	Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give			4h City Town or	Location of Death	APRIL	9 200 4c. County o		7:30AM M	
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	Funeral Director		5. Social Security Number 6. Social Security Number 1		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG. 15,	Year)	9. Birthp	place (State or Foreign http:/ YLAND	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD QUEEN		Town or Loc					1	0d. Inside City Limits 1 X Yes 2 □ No	
	h the r 28a notif	Director	10e. Street and Number	THIRD OF		10f. Zip Code		1	0g. Citizen of Wh	nat Cour	ntry?	
	23a c	ralD	307 N. COMMERCE	E STREET			1617			JSA		
	er deg items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		 Americ White, 	ean Indian, etc.	
36	ırs afte II", or i xamir	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1	1	I∐Yes 2∏XNo	Specify:		Specify:	W	HITE	
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12.5	be filed within 72 ho ital Hygiene. dother than "natur event, the Medical		12 17. Father's Name (<i>First, Middle, Last</i>)	4	CLERI	C OF DIST	RICT COUP 18. Mother's Name		STATE (RNMENT	
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ā	s 1 and 2 should f Health and Men Item 27 is marke other traumatic	T ₀	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	and Number or Run			itate, Zip	Code)	
	and 2 ealth a n 27 is		THOMAS D. DODD, S				E ST., CH	ENTREVIL	LE, MD 2	2161	7	
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	netery, cren	sition (Name of natory or other plac LELD CEME	CTERY APR.		20c. Location - C	-		
Salti	permit. Pag Department Important: I' any injury o		21. Signature of Funeral Service Lice	9///	22 F I	. Name and Addre	ss of Facility	& NEWNA	M FUNERA	L H	OME, P.A.	
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		shock, or heart failure. List only one cause on each line.										
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	ULI CONTRACTOR OF THE CONTRACT	_	venued					years	
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68760	cate b	ledical		d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnand					23d. Date	of deliv	erv	
Box.	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use	Physician/N	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)	/		Month Day Year			
Ö	w requires that the de been signed by the s should be detached	hys	9 □ Unknown	9□Unknown								
S, D	es tha gned be def	by P	Part II. Other significant conditions of		,	nderlying cause giv	en in Part I.				he cause of death?	
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Records,	e law has b e 2 st	Completed	/reform M	rellitu				24a. Was a autops	sy pi	rior to co	ppsy findings available impletion of cause of	
a			Hypertens,	h o m				1□ Yes				
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ō	g Phys er this eral dir	-	27. Manner of Death	28a. Date of Injury 2	28b. Time of				ow injury occurre		īy)	
<u>o</u>	tending Fleath. tor: After the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No					
Division or	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, office		28f. Location (Si City or Town		r or Rur	al Route Number,	
	pital o		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowl	ledne desti	n occurred at the ti	me date and place	and due to the o	cause(e) and mo-	ner ce	stated	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	on and/or in	vestigation, in my	opinion, death occur	rred at the time, o	date and place, a	nd due	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	May an		29c. Licens	se number	2	29d. Date signed		Day, Year)	
)			•	THE WON !		1	65755		4.9.	08		
	5 ADDIES		30. Name and address of person who	completed cause of death (Item 2) 32. Registar's Signatu 2008	AS FO	Print)	21601					
	Sta		31. Date filed (Month, Day, Year) APR 1 1	32. Regidar's Signatu	ire /K	South,						
	Registr	uı	ALK II	The state of the s	1	7						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 10 Day 2008 1:20 am[™] Μ. Dorak Helen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil 10 Halls Lane E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 2 | March | 2 | Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Months 1930 1 □ M 2 □ F 78 Swayersville PA 201-24-7522 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No New Castle Hockessin 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 19707 USA 505 Erickson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processor General Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Lajdik Thomas Dobias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkton, MD 21921 Thomas P. Dorak, Sr. 10 Halls Lane 20b. Place of Disposition (Name of Cemetery, crematory or other place Delaware Veterans Memorial Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 ₺ Removal from State 4 Depation 5 ☐ Other (Specify) Apr 16 2008 Bear, Delaware r Service Licensee 22. Name and Address of Facility 21. Sig ature of DE 19803 tnandler Funeral Home 2506 Concord Pike Wilm 23a. if rt1. Entur the disease, or complications that caused the nock, or leart failure. List only one or use an ach line. Imm. bar. Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Do not inter the mode of dying, such as cardiac or respiratory arrest, Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

> and burial-trar

attending physician

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To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After i

10

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certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a. State

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Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-di-al Examiner must be notified at

Maryland 21215-0036

Baltimore,

Examine Physician/Medical signed by the a d be detached f by Completed Be

2

Certification:

Medical

29a, Certifie

23b. Was decedent pregnant in the past 12 months? I∐Yes 2 XNo

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

thanky

J. Tras case referred to medical		26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 No	Н	ospital: 1 □ inpatient 2 □]ER/Outpatient	3 🗆 🛭	OOA Other: 4	□ Nursing H	ome	5 Residence	6 Other (Specify,
7. Manner of Death		28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d	. Describe how inj	ury occurred
1 Natural 5 Pending		(International Page 1 out)	11,017	M		2 □ No			

6 ☐ Could not be 3 Suicide determined 4 Homicide

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

	1	For State Registrar	•	artment of Health <i>rtificate of Death</i>		Reg. N	6000	13/20
Physicia	an	1. Decedent's Name (First, Middle, Last) Sarah Elizabeth Durney			2. Date of I Month April	D		3. Time of Death 5:30 a M
/Medic Examin	1100	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			c. County of Death	
A LAGIIIII		Chester River Manor		Chestertown	1		Kent	
Funeral Director		213-38-9963	e (In yrs. last birthday, 67 ^{Yrs.}	If Under 1 Year If Under Months Days Hours	7 24 Hrs. 8. Date of E Min. (Month, 1 10/29	Birth Day, Yea 1/40	9. Birthpl Count Mary1	ace (State or Foreign try) and
faryland show ed at	or	Usual Residence of Decedent 10a. State	10c. City, Town or L				10	0d. Inside City Limits 1 □XYes 2 □ No
the N 28a-1 notiffi	rect	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Count	try?
Mith t be		111 A Flatland Road		21620		USA		
be filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Sive	Ever in U.S. 13.	Was Decedent of Hispanic O if Yes, specify Cuban, Mexica		No-	14. Race - America Black, White, 6	etc.
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d within / giene. er than "r the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5	+)	e kind of work done during mo DO NOT use retired) maker			n Home	
be file	Be (17. Father's Name (First, Middle, Last)			ner's Name (First, Midd			
should be nd Menta marked imatic ev	ဥ	Omar Jones Husfelt			lred Ruth N			0-4-1
		19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Numl		-		Code)
is 1 and 2 should of Health and Men item 27 is marke other traumatic	-	Kathleen Dowd/ Caregiver 20a. Method of Disposition	20b. Place of Disp	2 Fairlee Rd.(position (Name of ematory or other place)	Chestertown Date) 21620 Location - City or To	wn, State
Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chesapea	ke Cremation			evensville	
permit. Departingont important inj		21. Signature of Funeral Service Licensee 23. Part1. Enter the disease, or complications that caused	w 1	22. Name and Address of Faci ellows, Helfer 30 Speer Rd.Cl	nestertown.	MD		
death certificate be executed Exam e attending physician and d for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of): a consequence of): a consequence of):					
the death certificate by the attending physiched for use as the t	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregrant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		-	23d. Date of delive Month	ery Day Year
v requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause given in Pari		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
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ital or Attend rs after death rai Director: led in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injuding, et	ury - At home, farm, s c. (Specify)	•	City or	Tówn, St		
To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	f examination and/or	investigation, in my opinion, d	eath occurred at the ti	ne, date a	and place, and due to	o the cause(s)
To Tool	Σ	29b. Signature and fills of pertilies n.p.		D360	1.1	29d. l	Date signed (Month, 4-14-0	Say, Year)
-0		30. Name and address of person who completed cause of d	leath (Item 23a) (Type ar's Signature	e, Print) 30 Speer Ro	BUB (The	stertaur	MD216

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:55 p_M RICHARD STAR DAVIS 4/3/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CHESTERTOWN NURSING & REHAB CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Director MD 217-30-8281 8/7/1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I fem 27 is marked other than "natural" ~- "any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **KENT** CHESTERTOWN 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 7248 POMONA RD. 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: WHITE 1 ☐ Yes 2 No Specify ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FARMER** AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM E. DAVIS CAROLEEN BRYAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7248 POMONA RD. CHESTERTOWN, MD 21620 JEANNE_DAVIS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4/4/2008 STEVENSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 rup 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause up a public. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mer o 7 years disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as anding l IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by eveloro-culor 2No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1□ Yes after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 25 No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To **4**Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Minner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated

State Registrar

31. Date filed (Month, Day, Year)

Susank.

29b. Signature and title of certifier

32. Registrar's Signature

516 Washington Ace

in, D

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koss in D

0

29c. License number

DOU 17036/Md. 4/408

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Mont 4 8 WiGL 12 2008 orge /Medical 4a. Facility Name (If net institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Monter \underline{n} Social Security Number rthplace (State or Foreign **Funeral** Days Months DOUNTRY) HANA Hours 67 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; If Item 27 is marked other than "natural"; or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 18613 Funeral Terrac 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) XITOV Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Amoako 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate Dock 20a. Method of Disposition Dougan on (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If ite any Injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State 24/03 Saltpond, Chana 5 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nelm 1814 Franklin Street, Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Spiratory Failure/Anoxic Encephalopruth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last eumonia Examine The law requires that the death certificate be executed el Sundrame mail Bou attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Liver Failure Trastate Cancer Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 1□ Yes 2 🔀 No the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

2008 APR 1 5 DHMH 17 Rev 1/200

1500 Forest Gien Road, Silver Spring, MD 20910 32. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Purnima

31. Date filed (Month, Day, Year)

Box 68760 P.O. Division of Vital Records,

Examiner **Funeral** Director r than "netural", or Itame 23a or 28a-f ehow the Medical Exeminer must be notified at hours after Maryland 21215-0036 other Mental ! is marked ages 1 and 2 should be not of Health and Mental: If Item 27 is marked Baltimore, permit. Pages 1
Department of H
Important: If Itel
eny injury or ott **Physician** /Medical Examiner physicien and s the burial-transit certificate be executed as use è certificate has been si rector, page 2 should I Certification; After death. after death Director: the in by within 24 hours at To the Funerel D filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ů, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 09 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CNTOV Month Year Dav VLADIMIR 2230 AM MPILL 8000 10 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1**X** M 2□ F 021-76-7835 71 Jan. 8, 1937 Russia Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 1 X Yes 2 □ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Feather Rock Drive 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mordukh Entov Eva Simanovskaya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Liya N. Kaplinskaya - Wife 416 Feather Rock Drive Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Menorah 4/13/08 Rockville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death METHSTATL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Month Vear Day 23e. Did tobacco use contribute to the cause of death? 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 1 Nation 2 ER/Outpatient 3 DO 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending investigation 2 Accident

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records,

or Attending Physiclan:

been signed by t should be detach certificate this After within 24 hours after deau...

To the Funeral Director: /

Examiner Physician/Medical Completed by Be မ Certification:

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at time of death 9⊟Unknown	5 ☐ Other (specify)
Part II. Other significant condition:	s contributing to death but not resulting in t	he underlying cause given in Part l

	1 X Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
26. Place of Death	(Check only one)
A Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
8c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
, office 28	Mr. Location (Street and Number or Rural Route Number, City or Town, State)
at the time data and place as	and all the Albert and

	(Check only 2 Medical Examiner: O
	29b. Signature and title of certifie
ı	30 Name and address of person who complete

3 ☐ Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

1 ertifying Physician: To the best of my knowledge, death occurred at the time no the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) dimanner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D29675

APML 11, 2009

d cause of death (Item 23a) (Type, Print)

6420 ROCKLOGE Dr. BETHERDA, MD mi 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

28e. Place of injury - At home, farm, street, factory building, etc. (Specify)

State Registrar

5

Medical

13733

Physici /Medic		1. Decedent's Name (First, Middle, Last) RICHARD C. EMRICK		2. Date of Death Month Day Year Prize Priz
Examir	3	4a. Facility Name (If not institution, give street and number) TATE HOSPICE HOUSE	4b. City, Town, or Location of Death LINTHICUM	4c. County of Death ANNE ARUNDEL
Funeral Director		5. Social Security Number 342-26-8158 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday 7. The second of 1.	v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Forei Country) ILLINOIS
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MARYLAND ANNE ARUNDEL	Location SEVERNA PARK	10d. Inside City Limi 1 □ Yes 2 X N
with the	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The Maryland is Hem 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral Director	1 □ Never Married 2 Married 1 □ Yes 2 Ma No If Yes, Give Year or Dates:	21146 3. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	Specify: WHITE
within 72 h ene. than "natu ne Medical	Completed	(Specify only highest grade completed) (Giv	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) ARCHITECT	king HOTEL INDUSTRY
nd 2 should be filed within and Mental Hygiene. It named where then traumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) CHARLES EMRICK		ne (First, Middle, Maiden Surname)
1 and 2 should Health and Men em 27 is marke ither traumatic		1 1 2		aral Route Number, City or Town, State, Zip Code) A PARK, MARYLAND 21146
permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	rematory or other place) NE CREMATION APRI	20c. Location - City or Town, State 1
Partificate be executed Example and Example and Example and Example and For use as the burial-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
	sician/Medical	in the past 12 months? 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
he law requires that the de has been signed by the gge 2 should be detached	d by Physic	Part II. Other significant conditions contributing to death but not resulting in the DEMENTIA, CIRRHOSIS, DECUBITAL ULCER	, 0	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unkno
The law req ate has been page 2 shou	Completed by	MALNUTRITION		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
sician: certifica irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Dea	ath (Check only one) Home 5 □ Residence 6 X Other (Specify)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical Certification: To	27. Manner of Death 1	y Work? M 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hospital 24 hours a Funeral I etely filled	dical Ce	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, de 2□ Medical Examiner: On the basis of examination and/or and manner stated.		
To the within to the comple	Mec	29b. Signature and tith of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type RUSSELL R. DeLUCA, M.D., 305 HOSPITA		29d. Date signed (Month, Day, Year) APRIL 8, 2008 NIE, MARYLAND 21061
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 0 9 2008 32. Pigistrar's Signature		
HMH 17 Rev 1/3	2001			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend It State of Maryland Department 95/96/98 and Mental Hygiene Per Verb Co. Certificate of Death Reg. No. 2 Amend Item#7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 10:20 a ^M April 2008 Florence Elizabeth Everitt 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2009 Goldsboro Rd. Queen Anne's Barclay If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2**1**F Director 215-22-9201 82 September 10,1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Queen Anne's Barclay 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2009 Goldsboro Rd. 21607 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes XXX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ∏ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 2yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Leutner Louis Atkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box Teresa Collier 184 Barclay, Md. 21607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation April 8, 2008 Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fellows Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service kicenses W.Cypress St. Millington, Maryland 21651 Approximate Interval Between Offset and Death 23a. Part1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as car lac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) MO Carcino /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 5 Aesidence 6 □Other (Specify) 27 Manner of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural
Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

death (Item 23a) (Type, Print)

pleted cause of

2008

32. Registar's Signature

0. Name and address of person who

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a-c,pt.11, 27, 28a-f per me g883 9-9-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Freedman a 930 M U 2008 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death columbia unard Cen Howard If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Se Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Cardiff, Age (In yrs. **Funeral** 1 ☐ M 2 🕱 F Months Days Hours Min. 111-56-7183 **Director** June 4, 1923 84 United Kingdom Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at 1 ☐ Yes 2 K No Director Maryland Howard 28a-f Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 5330 Dorsey Hall Drive, #329 21042 U.S.A. filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 Divorced Year or Dates White Completed item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Children's Aid Society 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked oth Be မှ Max Mendelsohn Esther Beckman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen M. Freedman - Son 10718 Midsummer Lane, Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or c 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State O 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 04/13/2008 Columbia, Maryland Signature of F ral Servic 12. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 at clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Nasal Bone Fractures complicating **Physician** ULV /Medical Examiner Hypertensive Atherosclerotic Cardiovascular Disease with Coumadin Therapy Sequentially list conditions, and you all go in a day cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATTOM APPARATED BY MEDICAL Examiner law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Atrial Fibrillation, Parkinson's Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 D∈ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending unknown^{PM} subject fell investigation 1 Yes **⊅**E No 2 XAccident 4-10-2008 within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Md City or Town, State) **Ellicott** City, **Md** determined 4 ☐ Homicide 5330 Dorsey Hall Dr. #329 ō residence Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m.1 2008 10 30. Name and address of person, who completed ause of death (Item 23a) (Type, Print) 7 Columbia

State

Registrar

31. Date filed (Month PR)

strar's Signature

2008

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 100) 11, 2008 Brandon Franklin Fa1k April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 16001 Shady Grove Road Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Days Hours Year 1 M 2 ☐ F 216-02-6837 33 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 21 Clearwater Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No if Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Randolph Clyde Alberta Elaine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph C. Falk - Father 21 Clearwater Court, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4/16/08 Wesley Grove Cemetery Gaithersburg, Maryland 5 Other (Specify) 21. Signature of Funeral Service Acense 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, even Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery 3 ☐ Ectopic pregnancy death Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probabiy

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f shidical Examiner must be notified

77 is marked other than "natu traumatic event, the Medical

Department of Health a Important: If Item 27 is any injury or other tra

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by t d be detach

the

peen :

has

certificate

After this

within 24 hours arren common To the Funeral Director; /

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To

	d
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of the second

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an	١.
	1
autopsy	
performed?	
1□ Yes 2 No	

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

					performed? 1□ Yes 2 N
edical				26. Place of Death (C	heck only one)
	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 Residence

7.	Manner of Death		
	1 Natural	5 Pending	
	2 Accident	investigation	
	3 Suicide	6 ☐ Could not be	
	4 Homicide	determined	

25. Was case referred to mexaminer? Yes 2 No

> 28a. Date of Injury (Month, Day Year) Apr 11 2008 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? Unk M 1 ☐ Yes 2 No

6 Other (Specify)

h 21 29a. Certifier 🛮 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rockuille

9b.	Signature and title of certifier	
	mm 1 Solckir mo DME	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number metical

29d. Date signed (Month, Day, Year)

State Registrar

Medical

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RR 31. Date filed (Month, Day,

BRECKER mo DME 32. Registre s Signature 2008

			State of Maryland / Department of Health and Mental Hygiene 1 - For State of Maryland / Department of Health and Mental Hygiene 5 per inf., g879,05/05/08dbb Death Reg. No.	3737
ď	rec	,	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.	Time of Death
b	Physici /Medic			8:37 M
	Examin		4a. Facility Name (If Not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		400	University of Maryland Medical Contain Baltimore	
	Funeral Director		227-43-0964 1 M 2 F 68 Yrs. Months Days Hours Min. (Manth. Day Sear) VIRGIN	(State or Foreign
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ir	nside City Limits
	Maryi f sho ied a	ō		TyYes 2 No
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	h with			
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mential Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Pivorced If Yes, Give 1 ☐ Yes 2 No Specify: Specify:	
2-0	72 ho natur ilcal	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working	у
2	ithin ne.	ם	Elementary/Secondary (0-12) College (1-4or 5+)	
2	lled w Hygiel her th	S	BUDGET ANALYST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
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ar.	2 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	le)
≥ oî	1 and 2 Health tem 27 I		VONDA WALKER/DAUGHTER 407 SHENANDOAH ROAD HAMPTON, VIRGINIA 23661	
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fureral Service Cicenses 22. Name and Address of Facility J. B. JENKINS FUNERAL 1 7474 LANDOVER ROAD LANDOVER, MARYLAND	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appl	roximate rval Between
	Physician		Immediate Cause (Final disease or condition Panal Canal set and Death	
	/Medical Examiner		Due to (or as a consequence of):	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Ind. Apr. Cause (Disease or injury	
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8760	cate be executed ohysician and the burial-transit	dical	d	
Õ	ertifica ing ph e as t	Med	IF FEMALE:	
O. Box	the death certific y the attending p iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Year
ords, P	w requires that the de been signed by the should be detached	þ	23e. Did topacco use contribute to the cat	
l Kecords,	has e 2	Completed	24a. Was an autopsy fin autopsy performed? performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No	ion of cause of
VITal	iysician: Th	BeC	25. Was case referred to medical 26. Place of Death (Charle calls care)	140
_	hys ⊟ ⊟ ii	2		
0 00	ndIng Ph th. : After th funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work? 2 Accident investigation 28d. Describe how injury occurred 1 Yes 2 No	
DIVISION	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rou City or Town, State)	ıte Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	
			(Condy Su , MD /19760 April 9, 2008	7
2	(6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cindy Lee It South Green Struct, Roam N3ECP, Buttonere, Many brul Z 31. Date filed (Month Day, Vag) 32. Benjetra's Significance	1(201
	Sta Registra	100	31. Date filed (Month, Day, Year) APR 1 5 2008 Security 32. Registrar's Signature	

DHMH 17 Rev 1/2001

			For State Registrar		State	of Maryla	•	artmen ertificat				лental Нус я	jiene leg. No.	200	3 13	73
П	Physic	an	1. Decedent's Name (First, Middle,	,	П.						2. Date of Dea		Year	3. Time of	
	/Medi	cal 🖟	Hazel		F.		inamore	T # 51				April II,			4:40 F	М
	Examir	ner	4a. Facility Name (If n 5003 Lee Hi			imber)				r Location	of Death			County of Dea	tn	
-	Funeral		5. Social Security Nur		.e S. Sex	7. Age (In y	rs. last birthday	Monro If Under		If Unde	r 24 Hrs.	8. Date of Birth		ederick 9. Bir	thplace (State o	r Foreia
d	Funeral Director		577–46–9410 Usual Residence of D		1 □ M X XF	96	Yrs.	Months	Days	Hours	Min.	Dec. 14,	1911	C/	nington,	_
	fand ow			Ob. County		10c.	City, Town or L	ocation		-					10d. Inside Cit	ty Limits
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	or 28a	irec	10e. Street and Numb	er				10f. Zip	Code			1	l0g. Citiz	en of What Co	ountry?	
	th wit	al D	5003 Lee Hi	ill Circ	le				2	21770				USA		
Maryland 21215-0036	permit. Pages 1 and 2 sho ifd be filed within 72 hours after death with the Maryland Department of Health and Nentral Hygi-ne. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if "Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4		12. Was Dec Armed F d 1 ☐ Yes If Yes, G Year or I	cedent Ever in orces? 2 MNo ive Dates:	U.S. 13.	Was Dece If Yes, spe 1 ☐ Yes		lispanic O an, Mexica Specify		pecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: Wh		
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	Health tem 27 other tr	2	20a. Method of Dispos			20b	D. Place of Disp cemetery, cre					Date		ation - City or	Town, State	
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Baltimore,	permit. Pag Department Important; I any injury o		21. Signature of Fune					2. Name ar				eorge P. K			-	
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.O. Box 68	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2√21 9 □ Unknown	onths?		birth 2□Fo nant at time o	etal death 3	□Ectopic pi □ Other (sp		<i>y</i>			2	3d. Date of de Month		/ear
Δ.	res that the signed by be detaction		Part II. Other signific	ant condition	s-contributing to	eath but not r	resulting in the	underlying o	ause giv	en in Part	I.	23e. Did to	bacco us	se contribute to	the cause of d	eath?
rds	equires en sign	d by	Ken	lin	suffe	rier	ry					1 □ Y	es 2	¶No 3□P	robably 4 □L	Jnknown
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ō	Phys this	- T	1 ☐ Yes 2 ☑ No 27. Manner of Death	0	28a. Date	· ·	ER/Outpatie		JA	4 LI N	lursing Ho	ome 5 Resid 28d. Describe h			ecify)	
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Division	in Itte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad Zee. Plac	e of injury - At ling, etc. (Spe	t home, farm, s ecify)	treet, factor	y, office			28f. Location (S City or Tow	treet and n, State)	f Number or R	ural Route Num	ber,
_	Hospital 4 hours Funeral ely filled	Medical Co	29a. Certifier 1- (Check only 2 one)	Certifying Medical E	Physician: To the kaminer: On the land mai	e best of my k basis of exam nner stated.	knowledge, dea ination and/or i	th occurred nvestigation	at the tin	me, date a opinion, de	and place eath occu	, and due to the orred at the time, o	cause(s)	and manner a place, and du	s stated. e to the cause(s	3)
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a de	(6)		30. Name and addres	s of person w	ho completed cau	se of death (It	tem 23a) (Type	Print)	11/.	941	57	Frelo		/ m	12120	,

State

31. Date filed (Month, Day, Year)
APR 1 5 2008 Registrar

hin 24 hours at Medical 29c. License number 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 750 D25 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANCHEZ 32. Registrar's Signature filed (Month, Day, Year) State MAR 3 1 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ELLEN C. HOWARD 30 MARCH 2008 2030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 604 SOUTH ST. EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
FEB 27, 1926 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 82 Director DELAWARE 221–18–6158 Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified 1 **X**es 2 □ No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 604 SOUTH ST. death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 2 3 👿 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES CAREY MILDRED DEPUTY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 Is any Injury or other trau J. WAYNE HOWARD/SON 7830 SHORE DRIVE, PRESTON, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY 4/3/2008 HURLOCK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON CHOL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Minule /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): saquer lially fet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit requires that the death certificate be executed Covo may Exam Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? ∕es 2∏ No death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Vital 1∐ Yes $\Delta \Lambda \Lambda$ 25. Was case examiner? 26. Place of Death (Check only one) No No Hospital: 1 | Inpatient ၉ 1 ☐ Yes 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) aston State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 25 PM HASELTINE MARCH 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOMUNS BAYLIEW MEDICAL CENTER BALTIMORE B. Date of Birth (Month, Day, Year) MAY 25, 1914 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 TF Hours 93 VA 225-34-0254 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edica Examiner must be notified at 1 ☐ Yes 2 No Directo TALBOT OXFORD MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 27966 OXFORD ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: <u>م</u> Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HISTOLOGY TECH. MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN HARPER LOU GREENE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA JORDAN/DAUGHTER 27966 OXFORD ROAD, OXFORD, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State ARLINGTON NATIONAL CEM 4/7/2008 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., FASTON, MD 21601 Ostrash C.F.S/2 M. Joseph of Strickle admit 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESALARDRY FAILURE disease or condition resulting in death) HERM /Medical Due to (or as a consequence of): Examiner LEURAL 2 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Jean) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): LECTLS Division or Vital Records, P.O. Box 68760 Physician/Medical SUBBURAL HEMATOINA WEEKS IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) the 9 Unknown n signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an perform ate 2 □ No the Hospital or Attending Physician: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 4 25 AM 1 ☐ Yes 2 🗷 No 2 Accident the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined HOSPITAL 219 S. WASHINGTON ST.

3

24

State Registrar

Medical

29a. Certifier

one)

(Check only

31. Date filed (Month, Day

29b. Signature and title of certifier

Isne

MO

une 30. Name and ress of person who completed c re e of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-300

AVENUE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 5:00Pm 2008 Roland V. Hercules April 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 7-23-1931 Tobago, WestIndies Director 126-44-7302 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No FLFlagler Palm Coast Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 32164 United States 37 Piedmont Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status filed within 72 hours after ☐ Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Black þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within th and Mental Hygiene. 7 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Healthcare Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simon Hercules Evelyn Hislop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bowie, MD 20720 Health tem 27 I Othneil A. Hercules (son) 11112 Maiden Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iten
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/16/08 4 Donation 5 Dother (Specify) Brentwood, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 7 Juliet hompsi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Renal Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and -trans death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sepsis 1 Tes 2 No 3 Probably 4 to Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law Dementia 24a. Was an page 2 has autopsy 1∐ Yes 2💢 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 | Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 4/13/2008

State

Registrar

14333 Laurel Bowie Road

32. Registrar's Signature

Laurel, MD 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syeid Said, MD

2008

31. Date filed (Month, Day, Year)

APR 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OB 1223 PM LOUIS APRIL 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTOOMER MOVENTIST HOSPITAL TAKOMA PARK WASHINGTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**½** M 2 □ F Raleigh, N.C. 11/20/1946 Director 579-64-1204 Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County iral", or Items 23a or 28a-f show Examiner πust be notified at Md. Prince George's Bladensburg 1 Yes 2 No Director the 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 5999 Emerson Street 20710 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Year or Dates: other than "natu vent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Md. Public Schools 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even Louis Edward Harris, Sr. Blannie Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trauonce. Terry Witherspoon/Daughter 4106 Hamilton St., Hyattsville, Md. _20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/18/2008 Washington National Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
22. Name and Address of Facility
32. Name and Address of Facility
33. Name and Address of Facility
34. Name and Address of Facility
34. Name and Address of Facility
35. Name and Address of Facility
36. Name and Address of Facility 21. Signature of Funeral Service Licensee , soll 25 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCIEROTIC CARDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) has been signed by the e 2 should be detached 9 I linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy rector, page 2 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ uneral dir this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation s after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of ceptifies

HAMMER, M.). 7600 Carroll Avenue, Takoma Park, Maryland 20912 DARCIE 31. Date filed (Month, Day, Year) 2008

Imo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

60319

29d. Date signed (Month, Day, Year)

APRIL, 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	State of Maryland		irtment of H tificate of L			eg. No.	08	13746		
	9	100	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day	Year	3. Time of Death		
	Physicia /Medic	al 🛊 🗕	Viola Eva Jameson March 28, 2008 10:									
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel									
	Funeral		1002 Boom Court 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	Annapoli If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		lace (State or Foreign		
	Funeral Director		578-26-1301 1□M 2\F 86	Yrs.	Months Days	Hours Min.	10/22/1	921	Mary			
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				1	0d. Inside City Limits		
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	r 28a- notifi	Director	10e. Street and Number		10f. Zip Code		1	l0g. Citizen o	f What Cour	ntry?		
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	r dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,			
20	s afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2XXNo If Yes, Give 3XXVidowed 4 □ Divorced Year or Dates:		1 □ Yes ¾ ∭ No	Specify:		Spec	cify: W	hite		
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yland	be fill htal H ed oth	Be	17. Father's Name (First, Middle, Last) Francis G. Swann			Jane E.		Traidon burn				
	should be and Mental marked umatic ev	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			er, City or Tow	n, State, Zij	o Code)		
N N	and 2 sealth ar n 27 is ner trau		John W. Jameson, Jr./Son	3688	O Bluewat	er Run,	Selbyvi	.11e, D	elawa	re 19975		
ē,	of Hea		20a. Method of Disposition 20b. Pl	ace of Dispo	sition (Name of matory or other place Veterans	ce)	Date	20c. Location	n - City or To	own, State		
Ē	Pages nent of ant: If its ary or o			emete:	rv	4/4/2	2008	Chelte	pham,	Maryland		
Baltimore,	permit. Pages Department of Important: If it any injury or o once.		21. Signature of Funeral Service Licensee		2. Name and Addre							
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			shock, or heart failure. List only one cause on each line.			9,	, , , , , , , , , , , , , , , , , , , ,	_ '	- 1	Interval Between Onset and Death		
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DHMH 17 Rev 1/2001

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į	Examin		4a. Facility Name (If not institution	. 0	•		4b. City, Town, o	r Location of	f Death		4c. County of	Death	
			Carroll County				Westmin				Carro		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (N	ate of Birth Month, Day, Y		 Birthplace Country) 	(State or Foreign
L	Director		578-48-9931 Usual Residence of Decedent	-X	0/	115.			07	/20/19	20 1	laine	
	and		10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d.	Inside City Limits
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	the 28a-	Director	10e. Street and Number	011	110	ew Wind	10f. Zip Code			100	g. Citizen of Wh	nat Country?	
	3a or	<u></u>	3795 Roop Road				21776	6			U.S.A.		
	death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in lorces?	U.S. 13.	Was Decedent of H		jin? (Specify Y	'es or No-	14. Race	- American I	ndian,
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'n	72 h 'natu dical	Completed	15. Deceder (Specify only highe	t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most	of working	16	6b. Kind of Busi	iness/Indust	ry
7	vithin ne. han '	пр	Elementary/Secondary (0-12)	College ((1-4or 5+)		mer Servi				Sears		
V	iled v Hygie ther t	ပိ	12 17. Father's Name (<i>First, Middle,</i>	fact)						t Middle Ma	aiden Surname)	
Z Z	d be f intal h ed of	Be	Samuel Shapiro	Lusty					tie Sch			/	
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	T ₀	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street					tate. Zip Co	de)
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Ď	permit Depar Impor any Ir		1 you f Kyco	ils		1	6000 Anna	apolis	Road,	Bowie	, Maryl	and,	20715
	ELL:		23a, Part1, Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not en	ter the mode of dyi	ng, such as	cardiac or resp	oiratory arres	st,	- Ap	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	only one outdoor on	a	C. Do	M :	1000	را م	lil	anchi	Or	set and Death
*	/Medical		resulting in death)	Due to	(or as a conse	equence of):	ringe		dial		There		2/11
	Examiner		Sequentially list conditions	b						V	,		7 1
	p ti	inel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence of):							
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ò	ficate be executed physician and sthe burial-transit	dical		d									
DOX O	certif nding Ise a	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, ou	atcome pf preg	nancy					23d. Date	of delivery	
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ŗ	s that ned t	by PI	Part II. Other significant conditi	ons contributing to d	death but not re	esulting in the u	inderlying cause giv	en in Part I.	2	23e. Did toba	acco use contrib	oute to the c	ause of death?
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5	ng Pi		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date (Mor	of Injury onth, Day Year)	28b. Time o	Wo			Describe how	v injury occurre	d	
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_	pital ours a eral I		29a. Certifier	ng Physician: To th	e hest of my ki	nowledge dea	th occurred at the ti	ime date an	d place, and d	ue to the cau	ise(s) and man	ner ac etate	.d
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical		Examiner: On the									
	To the within To the complex	Me	29b. Signature and title of certifie				29c. Licens	se number		290	d. Date signed	(Month, Day	/, Year)
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	C 1200		30. Name and address of person	who completed cau	se of death	ZJa) (Type,	Print)					(-0	
	1/20		DINESH S	KAIA	RIA	21	7 WACH	NOTA	N HG	7.5	WITET	52.414	DO MOZO

State Registrar 31. Date filed (Month, Day, Year) APR 0 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) April 2008 2145 Purnell Jones Sr 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis Months Days Hours Min. 0 Ct 29 Year 925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Marviand 82 Yrs. 10XM 2□ F 216-28-6379 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State Annapolis Yes 2 No Maryland Anne Arundel 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 21401 TISA 119 Clay St. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 [X]Yes 2 □ No If Yes, Give Year or Date 1: 9 44 4 - 46 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) 12th Food Service Naval Academy 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Florence Gross William Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21401 Alena Jones(Wife) 119 Clay St. 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veteran Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4-10-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wame Reases of & collisions Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. B. Rease MOC483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonic Due to (or as a consequence of) Ilens Sequentially list conditions, if any loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Gastoindestal Bieco. Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) _ 9 Unknown 9 Unknown 23e. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 26. Place of Death | Check only one)

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760,

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Division of Vital

Physicien:

Hospitei or Attending

Physician

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Show

in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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e filed within 72 hours after dail Hygiene.

permit. Pages 1 and 2 should be filled w Department of Health and Mentel Hygier important: If item 27 is marked other th any injury or other traumatic event, IDs once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical by Completed

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

investigation

determined

6 Could not be

5 Pending

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1/Natural

3 🗍 Suicide

29a. Certifier

2 Accident

4 Homicide

29c. License number DOC058297 29d. Date signed (Month, Day, Year)

30. Name and address of pers in who completed cause of death (Item 23a) (Typin, Print) MVD Annietha

Media Centre In

Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2008

32. Resistrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008^{ea} JAQUITH CHLORA April 11, 11:02 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 8, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 579-14-1283 1 □ M 2 🛛 F 87 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Silver Spring 1X Yes 2 □ No Maryland Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3352 Chiswick Court Bldg. 57-2F Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cost Accountant Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Evelyn Dement Langhorn Wister Shearer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 3352 Chiswick Ct.Bldg. 57-2F, Silver Spring, MD Wendell E. Jaquith, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 04/16/2008 Crownsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Jordan Funeral Service. Inc. 4001 Benning Rd., N.E., Washington, DC Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final **Physician** ACUTE CEREBRAL VASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🛣 No Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death.

Director: A

in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier April 12, 2008 D0064615 30. Wime and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Wroblewski Genevieve 31. Date filed (Month, Day, Yea 32. Registrar's Sign State **APR 15** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:19A M 2008 April Katherine Marian James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PIGTA IUISTA MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days Min. 1 □ M 2 🔀 F 87 335-18-4140 January 21,1921 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 2 No MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4206 Sandwich Circle 20601 USA 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Govt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Yara Mabel Spelina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jill Bikowski/Daughter 15120 Beacon Hill Circle, Swan Point, MD 20645 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Trinity Memorial Gar: 4/14/08 Waldorf, Maryland 4 □ Donation 5 □ Other (Specify) 22. AMBRANT-ECHOLS FUNERAL HOME, P.A. 21. Signature of Fup ral Service Licensee St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death Due to (or Ja consequence of): 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DIABILED MOLLETUS Due to (or as a consequence of) ADVANCEA ATTACKOSCLERUSET Due to (or as a consequence of) yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2

Physician /Medical Examiner Examine

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Certification: To

Medical

certificate be executed

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Division or Vital Records,

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within 24 hours a **To the Funeral C** Hospital

Physician

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filed within 72 hours after

and 2 should be Mental

Baltimore, Maryland 2121

Director

Completed by Funeral

Be

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/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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25. Was case referred to medical examiner? 1 ☐ Yes 2 No							26.	Place of Dea	th Check onl one
		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			3 🗆 🛭	DOA Other: 4 Nursing			ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 2 ☐ Accident	5 ☐ Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At building, etc. (Spe	home, farm, stree	t, facto	ory, of	fice		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD.

Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Athen

mproaké square su, te 103 haldort 20603 MD. e0196 31. Date filed (Month, Day, Year) 32. Pregistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 Ralph Francis Kessler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center SVIYMI If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Days 1⊠M 2□F 79 May 7, 056-22-8057 1928 New York Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Maryland Prince George's Bowie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 20715-2107 U.S.A. 12410 Salem Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11 Marital Status Black, White, etc. INYes 2□No USN
If Yes, Give
Year or Dates: 1946-'52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) United States Ith and Mental Hygiene.

7 is marked other than "r
traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) wermit. Pages 1 and 2 should be.
Department of Health and Mental Is Important: if Item 27 is menany Injury or other Be Gallagher George Agustus Kessler Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12410 Salem Lane, Bowie, Maryland 20715-2107 Doris M. Kessler/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Apr. 8, 2008 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequen-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Ö 9 Unknown ۵ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1° Inpatient 2 ER/Outpatient 3 DOA ဥ A er this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours af er death. e Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) within 24 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert

APR 0 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

KOM

9

Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: 24 hours

> State Registrar

29b. Signature

30 Name and address of person has completed cause of death (Item 23a) (Type, Print

E) MEN

APR 1

To the within 2

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DHMH 17 Rev 1/2001

29c. License number

00060301

29d. Date signed (Month, Day, Year)

(4) STES CHESTERTOWN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) AMonth & 2. Date of Death 3. Time of Death 2008 **Physician** 1240 PM KAMARA MELVIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1X M 2 ☐ F Months Days Hours Director 213-45-0413 45 MARCH 26 1963 SIERRA LEONE Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at MD PRINCE GEORGE'S LANHAM 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 HARDWOOD DRIVE 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 E No BLACK Specify: Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event the Man Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ARCHITECT yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be N'TUMA KAMARA ပ FODAY KAMARA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAMARA/WIFE 6309 HARDWOOD DRIVE LANHAM, MARYLAND 20706 CYNTHIA 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State FT. LINCOLN CEMETERY 4/19/2008 BRENTWOOD, MARYLAND J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic Daranasel Senus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to import in Due to for as a consequence of if any leading to immunicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Was an page 2 s has autopsy performed? res 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 TYes 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANAXU, MO 20706 8118 6000 LUCK ROAD MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State

Registrar

31. Date filed (Month, Day, Year)

2008

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		rtment of H	lealth and I Death		giene	008	13754
			Registrar 1. Decedent's Name (First, Middle	e, Last)		001	inouto or	Douin	2. Date of De	eath		3. Time of Death
	Physicia	_	Dorothy		Lazero	off			Month APRIL	10. 20	Year 008	10:15P ^M
	/Medic Examin	6 1	4a. Facility Name (If not institution	, give street and nu			4b. City, Town, o	r Location of Death			ounty of Death	
			COLLINGSWOOD NU					ROCKVIL			MONTG	
12.00	Funeral Director		5. Social Security Number 086-05-2092	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/23/	ay, Year)	Cou	olace (State or Foreign ntry) YORK
	70		Usual Residence of Decedent		10.00							
	arylar show d at	7	10a. State 10b. County MARYLAND MON	TGOMERY	100. Cit	y, Town or Loc	ROCKVILI	Æ				10d. Inside City Limits 1
	the M	Director	10e. Street and Number				10f. Zip Code			10g, Citize	n of What Cou	ntry?
	3a or	<u></u>	299 HURLEY AVEN	UE				20850			US	A
	death	Funeral	11. Marital Status		cedent Ever in U	.S. 13. V	Vas Decedent of h	Hispanic Orlgin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.))- 14	. Race - Ameri Black, White,	
9	s after	by Fu	1 ☐ Never Married 2 ☐ Marr 3 🌣 Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, G Year or D	2 🙀 No ive		☐ Yes 2 No	Specify:			pecify:	WHITE
-0020	2 hour	ed b	15, Deceden	t's Education		16a. Deced	ent's Usual Occu	pation		16b. Kind	of Business/Ir	ndustry
<u>د</u> ک	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	(Specify only higher Elementary/Secondary (0-12)) (1-4or 5+)		kind of work done OO NOT use retire EMAKER	during most of word)	rking		OWN HON	иF.
7	led wi lygien her th it, the		1.Z	/		HOM	ETHKLIK	18. Mother's Nar	no (First Middle			
and	ld be fil ental F ked otl ic ever	To Be	17. Father's Name (First, Middle, SAMUEL WIESEL	Last)				ROSE ST	*	, maideri o	umame)	
Mary	nd 2 shou lith and M 27 is mar r traumati	-	19a. Informant's Name/Relations LAURA ROSEN - I			19b. Mailin 17017	g Address (Street SIOUX L	and Number or ReAI	ural Route Numb THERSBUF	er, City or T RG , MA	Town, State, Zi RYLAND	^{o Code)} 20878
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			cemetery cren	sition (Name of natory or other pla D MEML G	DNS 04/1	Date 3/2008		ation - City or T	own, State H, VIRGINIA
Dalt	permit. Departm Importa any inju		21. Sign are of a neral Service	Licensee		22 E 1	Name and Addre DWARD SA 091 ROCK	ess of Facility GEL FUNE VILLE PI	RAL DIRI KE, ROCE	CTION CVILLE	, INC.	LAND 20852
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat							Approximate Interval Between
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	/Medical Examiner		resulting in death)	DEME DEME	o (or as a consec NTIA	quence of):						
lis		Jer	Sequentially list conditions, it any, leading to immediate	b. Due to	(or as a donesor	juence of):			_			-
	cuted	Examine	cause (Disease or injury that initiated events	c								
8760,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to	o (or as a consec	quence of):						
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XOR	n certif ending use a	In/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn		Ectopic pregnanc	200		23	ld. Date of deliv	*
מ ה	w requires that the death certific been signed by the attending p should be detached for use as	hysician/Me	in the past 12 months? 1 ☐ Yes 2 五No 9 ☐ Unknown		gnant at time of		Other (specify)	, y			Month	Day Year
ī.	requires that the een signed by th nould be detache	Д.	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the ur	nderlying cause gl	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
rds,	quires n sign	d by							1 🗆	Yes 2	No 3 ☐ Pro	obabiy 4 □Unknown
ecord	law rei as bee 2 shoi	Completed							24a. Was	s an	24b. Were aut	opsy findings available ompletion of cause of
	The ate h page	Com							perl 1∐ Yes	ormed?	death? 1 ☐ Yes	2 □ No
VItal	Physician: r this certificaral director,	Be	25. Was case referred to medica examiner?	Hospital:			Ot		ath (Check only			REHABLLITA:
_	ر Sir	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatien 28b. Time of	I JUDON		Home 5 ☐ Res			ity)TION_CENTER
0	nding F ath. r: After re funera	atior	1 Anatural 5 □ Pendir 2 □ Accident investi	194	onth, Day Year)	Injury		ork?]Yes 2				
UIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Plac buil	ce of injury - At h ding, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Ru	ral Route Number,
2	spital o		29a. Certifier 1⊠ Certifyii	ng Physician: To th	ne best of my kn	owledge, deatl	n occurred at the	time, date and place	e, and due to the	e cause(s) a	and manner as	stated.
	he Hoo in 24 h he Fur pletely	Medical	(Check only 2 ☐ Medical one)	Examiner: On the and ma	basis of examin inner stated.	ation and/or in	vestigation, In my	opinion, death occ	curred at the time	e, date and p	place, and due	to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifie		·D			se number D30132		29d. Date APRIL	signed (Month	, Day, Year) 108
)	7		30. Name and address of person			m 23a) (Tyne	Print)					
			DR. KITA CHOSH	, 14812 I	PHYSICIA	NS LAN	E, ROCKV	ILLE, MAR	RYLAND	20850		
	Sta Registr		31. Date filed (Month Day, Year, APR 1	4 2008 32.	Pogistrar's Sign	ature	ands 1					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAmended#10c perFH FCHD, KS Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 10 **Physician** April 3:34 P Thomas Edward Leopold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea MAR 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 1929 Brunswick, MD 219-22-8732 79 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 □ No 15 West Potomac Street, Brunswick Director Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21716 USA 15 West Potomac Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4or 5+) Elementary/Secondary (0-12) the Truck Driver Genstar Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be John Godfrey Leopold Margaret Lillian Welsh Abrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Leopold, Wife 15 West Potomac Street, Brunswick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopan on 5 D Øther (Specify) 4/15/08 21. Signatura Fundaryice Licensee

Williams, Owner Reformed Cemetery Knoxville, MD 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Discuss of right, that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? Day 5 ☐ Other (specify) signed by the a , the ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Hnpatient 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 27. Manner of Death 1 Natural 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. 400 C 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar		State of M	,	•	tificate of			Reg.	2111	8	13756
			1. Decedent's Name	(First, Middle, La	ist)					2. Date o Month	Death		ear	3. Time of Death
	Physici /Medic		Mary Jane	Minor AK	A Jane Ressir	ng Mino				Apr 10			- ai	12:25 a M
	Examir		4a. Facility Name (If	not institution, giv	re street and number)			4b. City, Town,	or Location of D	Death		4c. County of		
			Manor Can 5. Social Security Nu	e-Silver S		e (In yrs. las	t hirthday)	Silver If Under 1 Year	Spring	Hrs I a Date o		Montgome		lace (State or Foreign
	Funeral Director		203–10–907		1 ☐ M 2 🗙 F	88 88	Yrs.	Months Days	Hours 1	Hrs. 8. Date o (Month) Jan 7,	Day, Ye.	ar)	Coun	ace (State or Foreign try)
			Usual Residence of I							Jour 77	1010			
	rylan show	_		10b. County		10c. City,	Town or Lo						10	Od. Inside City Limits
	8a-f s	Sct	MD	Montgome	ry 		Sil	ver Spring			1			1 □Yes 2 🕅 No
	with the	Funeral Director	10e. Street and Num					10f. Zip Code			10g.	Citizen of Wha	at Coun	try?
	ns 23	eral	910 Rando	ıpn koad	12. Was Decedent	Ever in U.S.	13. \	20904		? (Specify Yes o	r No-	USA 14. Race -	Americ	an Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hipty or other traumatic event, the Medical Examiliar must be notified at ance.	þ	1 ☐ Never Marrie 3 🕱 Widowed 4	_	Armed Forces? 1 □Yes 2X If Yes, Give Year or Dates:			Was Decedent of fYes, specify Cul I □Yes 2∑No		uerto Ricán, etc.)	Black, Specify:	White, e	
2-0	72 hou	sted	(Specie	15. Decedent's E fy only highest gr	ducation		16a. Dece	tent's Usual Occu	pation	f working	16b	. Kind of Busir	ess/Ind	lustry
21	ithin 7	Completed	Elementary/Secon		College (1-4or	5+)		kind of work done OO NOT use retire	*	working				
121	led w Hygiel her th		12 17. Father's Name (F	First Middle Leet	1		Payro	11 Officer	T	Name (First, Mid		ederal G	oven	ment
Maryland	d be fi	Be C		Ressing	,					Ellen Lin				
ary	should be f and Mental I s marked of umatic eve	ပို	19a. Informant's Nar	me/Relationship	(Type. Print)	T	19b. Mailir	g Address (Stree					ate, Zip	Code)
	and 2 ealth a n 27 Is er trai		Donna H. M:	ichaels /	Daughter		6583	Dovecote D	rive, Col	lumbia, MC	2104	4		
ore,	of He of He rothe		20a. Method of Dispo] D Otata	20b. Pla	ce of Dispo	sition (Name of natory or other pla	ice)	Date	20c	. Location - Ci	y or To	wn, State
Ĕ	Pages ment of l ant: If its ury or o			5 ☐Other (Speci	Removal from State fy)		ional	Memorial H	ark Apı	r 14, 2008		urel, MD		
Baltimore,	permit. Departr Importa any inj		21. Signature of Fun	neral Service Lice	nsee			. Name and Addr O Universi						ome Inc.
			23a. Part 1. Enter the shock, or hear	e disease, or com t failure. List only	plications that caus one cause on each li	d the death. he.	Do not ent	er the mode of dy	ing, such as ca	rdiac or respirato	ry arrest,			Approximate Interval Between
-	Physician		Immediate Cause (F disease or condition resulting in death)		a. respi	ratory	failur	e						Onset and Death
1	/Medical Examiner		resulting in death)	•	Due to (or as		nce of):							
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o,	icate be executed physician and the burial-transit		resulting in death) La	ast	Due to (or as	a conseque	nce of):							
68760,	ate be hysicii he bu	fedical		•	d									
39	ertifica ling pl e as t	Med	IF FEMALE:									1		
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	pregnant nonths? No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnar Other (s <i>pecify)</i>	cy		_	23d. Date of Month		ry Day Year
₽.	that ned by deta		Part II. Other signific	cant conditions	contributing to death b	ut not result	ng in the u	nderlying cause gi	ven in Part I.	23e. I	Did tobaco	co use contrib	ute to th	e cause of death?
Records,	quire; an sig uld be	ed by					~			_ 1	□Yes	2 □ No 3	☐ Prob	ably 4XI Unknown
တ္တ	e law requir has been si e 2 should b	Completed									Vas an	24b. We	re autor	osy findings available
Œ.	The la	E O									utopsy enformed es	l? dea	ith?	npletion of cause of 2 □ No
Vital	nysician: Th nis certificate director, pag	Be (25. Was case referre	ed to medical						Death (Check o				
of \	Physic this o al dire	၉	1 Yes 2 1 N					I 3 L DOA		ng Home 5 ☐ F			(Specif))
	of the line	ation:	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigatio		y, Year)	8b. Time of Injury	Wo	iryat irk? ∐Yes 2∐No		ibe how i	njury occurred		
Division	al or Atta s after de al Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of in	ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location City of	on (Street Town, S	t and Number tate)	or Rura	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 X Certifying P 2 Medical Exa	nysiclan: To the best miner: On the basis of and manner st	of examination	edge, deatl on and/or in	n occurred at the vestigation, in my	time, date and popinion, death	place, and due to occurred at the ti	the caus	e(s) and manr and place, and	ner as s d due to	tated. the cause(s)
	Vithi Vomp	ž	29b. Signature and to	itle of certifier		11		29c. Licen	se number		29d.	Date signed (Month, l	Day, Year)
	20) f	ration	na fait	hook	=, M.	D6248	38		Apr	cil 11, 2	2008	
	QU.		30. Name and addre	ss of person who	completed cause of o	leath (Item 2	3a) (Type,	Print)						
	_	to	Pratima Pat	hak, MD	1500 Forest (Slen Ro	d, Sil	lver Spring	, MD 209	10				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Vear 474 /Medical 4a. Facility Name (If not institution, give street and number) Examiner GROVE SHAD ATIVENTISTHO GOCKVIlle Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1**⊠**M 2□F Hours 282-26-7701 Director 7, 1930 Dec. Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show iner must be notified at 1 ☐ Yes & ☐ No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13105 Harbor Lane Funeral 20657 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWI 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Is marked other aumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nick Masula Eva Hrnko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Gladyszewski-sister permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra P.O. Box 395, Randolph, Ohio, 44265 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4-15-2008 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 Con y 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESPIDATORY lay /Medical Du to (or as a consequence of): Examiner EMOPNEUMOTHORA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed MEUNIONIA attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NCREATIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Inpatient 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🔲 No 2 Accident 6 ☐ Could not be

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

State

341

3 ☐ Suicide

29a Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifier

NIDHI

determined

SINGH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9901 MEDICAL CENTER DAINE POCKVILLE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

me and address of person who completed cause of death (Item 23a) (Type, Print)

NIKHANJ

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 12:05 PM Sidney Malet April 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3110 Gracefield Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 □ F 14, 1918 90 Director 115-01-6078 Jan. Pennsylvania Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 'natural', or items 23a or 28a-f shov dical Examlner must be notlfied at Prince Georges 1X Yes 2 No Director MD Montgomery Silver Spring the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code death with 3148 Gracefield Road #313 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White ρ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CPA Accounting traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Arthur I. Malet Rose Friedland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau Jeffrey Malet - Son 3148 Gracefield Rd. #313 Silver Spring, MD 20904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 9 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon 4/13/2008 Adelphi, Maryland 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc
1170 Rockville Pike Rockville, MD 20852 permit. 21. Signature of Funeral Service Licenses Donald tottlemeer 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Bladder Cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse juence of Examiner The law requires that the death certificate be executed Prostate Cancer physician and is the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No ed by the detached 9☐Unknown 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? certificate 1∐ Yes 2 No or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

20

State Registrar

29b. Signature,

and tile

rtifie

Eugenio S. Machado, MD 31. Date filed (Month, Day, Year)
APR 14 2008

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Rd. Silver Spring, MD 20904 32. Signature

29c. License number

D24035

29d. Date signed (Month, Day, Year)

April 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MACNAUGHT COUATNEY 1:00 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** General Hospital Howard Howard County Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**™** M 2□ F 220-56-7215 41 Feb. 7, 1967 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director Maryland Howard Clarksville 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21029 5385 Broadwater Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Medical Billing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Harold R. MacNaught, Jr. Patricia Ann Adams ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12508 Silverbridge Lane, Laurel, MD 20708 Patricia Ann MacNaught/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate16, 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Francis J. COLLLIS Functs.

500 University Blvd., W., Silver Spring, MD 2
Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final SEMJIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IMMUNOSUAPLESSION Sequentially list conditions in a y, leading to find out cause. Enter Underlying Cause (Disease or injury that initiated events Examiner bunal-transit ANEUMONIA resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No Certification: To

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician

buld be filed within 72 hours after death with the Maryland Mental Hygiene.

Baltimore, Maryland 21215-0036

or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

within 24 hours a

To the Funeral I

Phys	9 ☐ Unknown		9LI Unknown								
by	Part II. Other significant cond	litions co	ntributing to death but not resi	ulting in the underlyin	g caus	e given in Part I.		23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkn			
Completed								opsy formed?	24b. Were autopsy fin prior to completic death? 1 ☐ Yes 2	on of cause of	
Be (25. Was case referred to medi	ical				26. Place of Dea	th (Check only	one)			
0 B	examiner? 1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3□	ome 5□Res	me 5 Residence 6 Other (Specify)					
ation:	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	iding estigation	28a. Date of Injury (Month, Day Year)								
Certification:		ıld not be ermîned	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac y)	tory, of	fice	28f. Location City or To	(Street and own, State)	d Number or Rural Rout)	e Number,	
Medical (rsician: To the best of my know iner: On the basis of examina- and manner stated.							ause(s)	
Me	29h Signature and title of cert	tifier			29c. Li	cense number		29d. Dat	e signed (Month, Dav.)	rear)	

29c. License number

10053051

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

10632 Little Patuxent Pkwy., #406, Columbia, MD 21044

29d. Date signed (Month, Day, Year)

AANIL 12

2008

Atha, 31. Date filed (Month

29b. Signature and title of certifier

Walter F.

egistrar's Signature

State Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

14

2008

Registrar's Signature

State Registrar Annapalis, UR 21401

30. Name and address of person who completed cause 4 death (Item 23a) (Type, Print)

State Registrar WILLIAM H. WOOD,

filed (Month, Day, Year) APR 0 2 2008

31. Date file

JR.

32. Registrar's Signature

M.D. 501 DUTCHMANS LANE EASTON, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 2. Date of Death **Physician** Year 0840AM Joseph Martin Mullaly 1ARCh 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Easton Pasto Memorial la If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours **M**□M 2□F Days 074-24-4204 7-20-1920 87 Manhatten, NY Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Md Talbot St. Michaels 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Cove View Dr. 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 Never Married X Married land 21215-0036 1 ☐ Yes X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 years College (1-4or 5+) real estate, insurance Self employed permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event: the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Mullaly Ellen Mahoney Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Mullaly (wife) 304 Cove View Dr., St. Michaels, Md.21663 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State **№** Burial 2 □ Cremation 3 □ Removal from State MDVA Cemetery 4-1-2008 Hurlock, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, applying the shock, or heart failure. List only one cause of each line. Immediate Cause (Final Spiration Meumonia. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Clostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**17** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 0065528 08

3+VA

State

Registrar

31. Date filed (Month, Day, Year) MAR 2 8 2008

Labib

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



, Easton MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 1.20 M LEROY W. MESSICK 26,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital at Easton Memorial Talbo Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV 23,1919 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 **X**M 2 □ F 217-09-6069 88 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 XYes 2 □ No Director EASTON TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any InJury or other traumatic event, the Medical Examiner must be or 21601 USA 311 OAK AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 【XNo Specify. <u>ک</u> Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) AUTOMOBILE MECHANIC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOTTIE SMITH WALTER MESSICK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23149 TUCKAHOE SPRINGS DRIVE, DENTON, MD 21629 BARBARA D. MITCHELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State CHESAPEAKE CREMATION CTR 3/28/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 YOHN MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or-respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LONGATIVE 2 walks /Medical Due to (as a consequence of): Examiner Chronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due Hor as a consequence of): burial-trar physician Physician/Medical the ! use as attending IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 100 1-Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury the Funeral Director: Af 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manper-stated.

P.0. Records, Division or Vital or Attending

certificate be executed

Box 68760,

Baltimore, Maryland 21215-0036

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LUDWIG J. State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 IDLEWILD AVE., EASTON, MD 21601 EGLSEDER III M.D.

31. Date filed (Month, Day, Year)
MAR 3 1 2008 32. Registrar's Signature

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

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E, p	hysici		Decedent's Name (First, Middle, Last JAMES D. MCKEI					2. Date of Deat Month MARCH	Day	Year 008	3. Time of Death 11:58PM
	Medio/ Examin	100	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	1-	4c. County of		11.JOFH
			WILLIAM HILL C	ARDENS		EAST	ON		TA	LBOT	:
F	uneral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 12,			place (State or Foreign
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rland	ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
Магу	a-f sh ifled	tor	MD TALBO	E	EAST	ON					Yes 2 □ No
th the	or 28)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Cour	ntry?
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent if Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specity Cub 1 ☐ Yes 2X No		pecify Yes or No- p Rican, etc.)	Black	· Americ · White,	
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Maryland nd 2 should be file lith and Mental Hy	ked o ic eve	To Be	EDWARD MCKELVEY				MARG	ARET ECH	OLS		
ary shou	s mar umat		19a. Informant's Name/Relationship (7	vpe. Print)	19b. Maili	ng Address (Street				State, Zip	Code)
and 2	ertra		DOUGLAS MCKELVEY	//SON	276	80 GOLDS	BOROUGH N	ECK RD.,	EASTON	, MD	21601
es 1 a	f item or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	own, State
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r <	this certificate has al director, page 2	일	examiner? 1 ☐ Yes 2 ☐ №6	Hospital: 1	nt 2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 X Nursing H	ome 5 🗆 Reside	ence 6 □Othe	er (Speci	fy)
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10	ว		30. Name and address of person who o	ompleted cause of d	eath (Item 23a) (Type	Print)	a	(. ^		
10			Russel A SU	rethen De		Cynwood	V DV EC	eston 1	20 21	401	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	•					

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 0 2 2008

	_1	For State Registrar				rtificate of I			Reg. No.	_ 0 0 0	10/1	
Physiciai		Decedent's Name (First, Middle JAMES						2. Date of De Month	Day		3. Time of Dea	
/Medica Examine		4a. Facility Name (If not institution 29541 BROOKS		umber)		4b. City, Town, or		MARCH ath	4c.	9 2008 County of Death TALBOT	7:20AN	
uneral irector		5. Social Security Number 083-38-4505	6. Sex 1 X M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days			ay, Year)	9. Birth	place (State or Fo	
a-f show filed at		Usual Residence of Decedent 10a. State 10b. County MD TA	LBOT	10c. C	City, Town or Lo				10d. Inside City Limit			
23a or 28a sst be not	5	10e. Street and Number 29451 BROOKS	LANE			10f. Zip Code 21	625		10g. Citiz	en of What Cou	ntry?	
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even	10 Be	17. Father's Name (First, Middle, CHARLES MATHE)						ame <i>(First, Middle</i>		Surname)		
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Important; any Injury once.		21. Signature of Funeral Service		· C	c 0 F1	KE CREMAT 2. Name and Addres ELLOWS, H	ss of Facility ELFENBE	IN & NEW	NAM F	UNERAL I	• "	
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hysician and the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse								
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a) := -	Ical	29a. Certifier (Check only one) CertifyIn 2 ☐ Medical	Examiner: On the	ne best of my kr basis of examin nner stated.	nowledge, death nation and/or in	occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) date and	and manner as s place, and due t	tated. the cause(s)	
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Completely fi	2	29b. Signature and title of certifier	1/m			D (d	number		3.	signed (Month,	Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 09:15 AM Donald Eugene McKinney April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7 Kirks Mill Lane Cecil North East If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 219-44-8964 62 25,1945 Sept. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2000No Maryland Cecil North East Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 7 Kirks Mill Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. and 2 should be filed within 72 hours after of ealth and Mental Hygiene. n 27 is marked other than "natural", or iten 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify White Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Bruce McKinney Mildred Irene Wharton other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Catherine McKinney / Spouse 7 Kirks Mill Lane, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East
Methodist Cemetery 20c. Location - City or Town, State $\mathtt{Apri}^{\mathtt{Date}}$ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Injury (14, 2008 North East, Maryland 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 10 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one hause on each (ne. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the SB 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 8 No autopsy performed: 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: director. this After after death

21215-0036

Maryland

Baltimore,

Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death

oria) (V 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL Physician **JAMES** EDWIN Mc KEEVER 2008 4:30 р м 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17801 MARDEN LANE SANDY SPRING MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F 578-40-0167 Director 83 Oct. 6 1924 Washington, D.C. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ıral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Md. Montgomery Sandy Spring Director 10e Street and Number 10g. Citizen of What Country? 10f, Zip Code 20860 17801 Marden Lane United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced WWII "natural" 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Excavation Corporation Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental h and Mental McKeever, Sr. Regina Kellerman Robert ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 17801 Marden Lane, Sandy Spring, 20860 Melba M. McKeever / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 □ Cremation 3 □ Removal from State Mt. Carmel Cemetery 4/14/08 Sunshine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service License murie 20882 Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident nin 24 hours after death the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within? To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41 (0) 5454 Wisconsin Ave., #1300, Chevy Chase, Md. 20815 Nelson G. N. Kalil, M.D. 31. Date filed (Month, Day, Year) 32. Registrans Signature State 4 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:58 AM Thomas Miles April 2008 Murray, Jr. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER Charles LaPlata 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 157-30-8709 67 Director March 22,1941 New Jersey Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 □ No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 249 Heather Court 20646 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Ill Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinanone. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔯 No Specify Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Installation Technician Telecommunication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude M. Lade Thomas Miles Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11871 Knollcrest Lane La Plata MD 20646

Date | 20c. Location - City or Town, State Stephen Murray/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Newport Cem. 4/15/08 4 Donation 5 Dother (Specify) Charlotte Hall, MD 21. Signature of Funeral Service License M01458 22 Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on data line. Septiceura Immediate Cause (Final disease or condition resulting in death) **Physician** esteria /Medical Due to (or onsequence of): Examiner necumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-tran IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ponknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Ratural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Maryland

Baltimore,

To the Hospital or Attending

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Medical

DHMH 17 Rev 1/2001

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D-46979

30. Name and address of Terson who completed cause of death (Item 23a) (Type, Print)

COLLINS P. SEIN, M.D. 3460 OLD WASHINGTON RD, SUITE 2031, WALDORF. MD 20602

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Desagnon of Mathiand Mental Hygiene Certificate of Death Reg. No. 2 Reg. No. 2008 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** McCassie Month ussel l 8006 /Medical 4a. Facility Name (If not institution, give street and number) Luiversity of Manyland Medical Ctr.
Social Security Number 6. Sex 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day Year | November 17,1935 Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 □ F 030-24-9215 72 MA Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 28a-f show MD Charles Marbury Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or; ury or other traumatic event, the Medical Examiner must be r 20658 5440 Grinder Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specific 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elbert W. McCassie Lena M. Aucoin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5440 Grinder Rd. Marbury, MD 20658 Mary McCassie/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 4/18/08 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 N Burial 2 □ Cremation 3 □ Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. Cehn 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep515 Due to or as a consequence of): /Medical Examiner oinourusnia Sequentially list conditions, if any, leading to immediate cause. Litter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed icle collision motor vel burial-trag Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by aortic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hyocardial Wfanction 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an performed? 1□ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To o After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division Injury 1 Natural hours after death. 2 Accident 3 ☐ Suicide 1 ☐ Yes 2 No 3.21.0B ~ 1'20 motor vehicle rollover 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Buyal Route Number, City or Town, State) Rt. 224 at Chicamuxen Rd., Marbury, MD 4 Homicide ō Street within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006-0747 MO 04-11-2008

Registrar

State

DB 1091

22 S. Greene Street Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Thomas E

APR 1 4

31. Date filed (Month, Day, Year)

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To the Hospital within 24 hours To the Funeral completely filler	Medical C	29a. Certifier 1 Certifying Physone) 2 Medical Examin	er:On the basis of exa	ny knowledge, dea amination and/or in	ath occurred at the ti nvestigation, in my o	me, date and place, an pinion, death occurred	nd due to the caus	e(s) and manner as stat and place, and due to th	ed. ne cause(s)
	Me	29b. Signature and title of certifier	and manner stated			License number		29d. Date signed (Mo	nth, Day, Year)
10		Carol	Hall	di		O.C.M.E.		April 10, 2008	
		30. Name and address of person wh Carol Allan, MD Assis	tant Medical Exa		Penn Street, Ba	altimore, MD 212	01		
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ORIGINAL

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Ž	alth a		Elaine C. Brince	field /Daught	er	l					lphi, M			2.0000)	
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			23a. Part 1. Enter the disease shock, or he rt failure.	, or complications that	caused the deat	h. Do not ent	er the mode of	of dying,	such as o	cardiac or	r respiratory	arrest,	-	Approximate	-
	Physician		Immediate Cause (Final disease or condition											Interval Between Onset and Death	
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Š Q	atter for u	ian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No	1 ☐ Live	birth 2 Peta	I death 3	Ectopic preg					2:	3d. Date of de Month	elivery Day Year	
5	y the	ysic	1 ☐ Yes 2 전 No 9 ☐ Unknown	9 Unkr		ieatn 5∟	Other (speci	ty)						Juy 10u	
ν. Γ.	mar ned b deta		Part II. Other significant cond	litions contributing to d	eath but not resi	ulting in the un	derlying caus	e given i	in Part I.		23e, Did	obacco us	e contribute t	o the cause of death?	
cords	e law requires that the dr has been signed by the e 2 should be detached	d by	diabetes			J	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3						robably 4 Unknown	1
5	beel shou	Completed	dementia								-	Т			
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֓֞֞֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֡֓֓֡֓֡֓֡	ifficat or, pa	ပို	25. Was case referred to med	anl								rmed? 24 No	1 ☐ Ye	s 2 🗆 No	
5	nysician; The le	∞ ∣	examiner?	Hospital:				Other			(Check only o				_
5 8	After this	<u>ان</u>	27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time of		Injury at			e XX Resi		Other (Spe	ecify)	
5	th. :: After e funera	텵	1 Natural 5 Pen 2 Accident inve	ding <i>(Mon</i> stigation	th, Day, Year)	Injury		Work?	s 2 □ Ne		54. D0001150	non injury	occurred		
2 5	r deg	ij	3 ☐ Suicide 6 ☐ Cou	rminod 28e. Place	of Injury - At ho	me, farm, stre					Bf. Location (Street and	Number or R	ural Route Number,	-17
5 3	a afte	Certification:	4 Homicide	buildi	ng, etc. (Specify	v)					City or To	vn, State)		ara riodic ridinoci,	
IIOISINIO	hour Inera Iy fille		29a. Certifier (Check only 2 Medic	ying Physician: To the	best of my know	wledge, death	occurred at t	he time,	date and	place, a	nd due to the	cause(s)	and manner a	s stated.	_
1	To the Pospital Of Attending Within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical	one)	at Examiner: On the b	asis of examina ner stated.	tion and/or inv	estigation, in	my opini	ion, death	occurre	d at the time,	date and p	place, and du	e to the cause(s)	
Ę	Fig. 5	2	29b. Signature and title of certi	fier	1010	. 1	29c. Li	cense nu	umber	7		29d. Date	signed (Mon	th, Day, Year)	
	5		Marie	MIN	1010/h	N M	1 0	190	1 di	5		411	2/2/1	1 &	
			30. Name and address of pers	on who completed caus	e of death (Item	23a) (Type, P	rint)					1/1	V/ Orul		_
			Marie A. Dobyns	7350 Van Duse			el, MD 2	0707							
	Stat Registra	e	31. Date filed (Month Pay, Ye	4 2008 32.	gistrar's Signat	B A	B . AF .								
	- region a			/4		AS AND									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Earl Francis Newsome April 2008 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15 M 2 F **Director** 218-14-1809 93 6/23/1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No Director MD Chestertown Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 200 Morgnec Rd 21620 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No þ Specify: White 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance State Hwy Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Newsome Margaret Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Newsome/sister in law 24454 Lambs Meadow Rd Worton, MD 21678 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 4/8/2008 4 Donation 5 Dother (Specify) Chestertown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 SpeerRd Chestertown, MD 21620 son Fella 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** D /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directs (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical as for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 thknown 1 ☐ Yes filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending 0

within 24 hours a To the Funeral C

State Registrar

DHMH 17 Rev 1/2001

5

31. Date filed (Month, Day,

29b. Signature and title of conifie

(Check only one)

Name

and address of person who completed cause of death (item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

0006030

29d. Date signed (Month, Day, Year)

SPEAR RD STES COTESTENTOWN, MA)

ORIGINAL

08-02563
Salomon Noubissie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Amend #5, PerFHPQC4_15_08cm	Cor	tificate of Dea			Reg. No. 20	108 377
Physic		Decedent's Name (First, Middle,Last)		OTT.		2. Date of De	eath	3. Time of Death
ledical Exam	iner	SALOMON 4a. Facility Name (if not institution, give street and numb	NOUBIS		, Town, or Location	Month March 3	1, 2008 4c. County of	2122 hrs
		Prince George's Hospital Center	31 <i>)</i>	1 '	verly	oi Deatii	Prince Ge	
Funeral Director		none	Age (In yrs. Ia	est birthday) If Un Mon Yrs.	der 1 Year If Und	Min.	Birth(MM/DD/YYYY) 30 1943	Birthplace (State or Foreign Country) CAMEROON
r any		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor	MD PRINCE GEORGE'S		LANDOVER				1 X Yes 2 No
the Mary 3a or 28a otified at	Director	10e. Street and Number 1506 ROOSEVELT AVENUE			ip Code 20785		10g. Citizen of What	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tend 71 is marked other than "natural", or items 23a or 28a-f sho reammatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Year		If Yes, spe		gin? (Specify Yes or I i, Puerto Rican, etc.)	White,	American Indian, Black, etc. AFRICAN
ours aft atural'	d by	15. Decedent's Education (Specify only highest grade of	ompleted)	16a. Decedent's Usua	al Occupation (Give	kind of work done	Specify: 16b. Kind of Busi	ness/Industry
336 thin 72 hours a ne. than "natura edical Examin	Completed	Elementary/Secondary (0-12) College (1-4 of 5+	or 5+)		orking life. DO NOT		PRIVA	TE
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", injury or other traumatic event, the Nedical Examinar.	Be Cor	17. Father's Name (First, Middle, Last) NOE KAMGA		<u></u>		r's Name (First, Middle BECCA NGA	, Maiden Surname) ANTCHEU	
MD 21 ad 2 should 1 alth and Mer m 27 is mar	To	19a. Informant's Name/Relationship (Type, Print) AISSATOU MONTHE/COUSIN				onber or Rural Route N		, State, Zip Code) BORO, MD 20774
re, h s 1 and f Healt if item		20a. Method of Disposition 1		Place of Disposition (No prematory or other place		Date	20c. Location - 0	City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:	Otato	MILY PLOT		5/15/2008	BAKASSA	, CAMEROOM
Bald permit Depart Impor		21. Signature of Funeral Service Licensee		7474	nd Address of Facilit	ROAD LANDO	VER MARYI	UNERAL HOME AND 20785
Physician /Medical		23a. Part 1. Enter the disease, or complications that caus fallure. List only one cause on each line.		Do not enter the mode	e of dying, such as o	ardiac or respiratory a	arrest, shock, or hear	t Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Stab wound or Due to (or as a condition resulting in death)						Death
	٠	Sequentially list conditions, b.		,				
	Examiner	if any, leading to immediate cause E.n.a Undersing Cause (Disease or injury that initiated						
uted nd ransit		events resulting in death) Last Due to (or as a cord.	nsequence of	f):				
'60, rate be executed physician and he burial - transi	Medical	UNPENDED AMENDED			-			
Division of Vital Records, P.O. Box 68760, Rospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Hoursal Direct After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Me		ome of pregr	2 Fetal deat		c pregnancy	23d. Date of d Month	elivery Day Year
O. Bo It the deal by the al	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to de	ath but not ro	eculting in the underlying	ag cauca given in P	net 23e Dic	I tohacco uso contrib	ute to the cause of death?
ires that the signed by	by	Contracting to do		souting in the underlying	ig cause given in Fa			Probably 4 Unknown
of Vital Records, ng Physician: The law require nfler this certificate has been si meral director, page 2 should b	Completed				·	per	opsy pri formed? de	ere autopsy findings available or to completion of cause of eath? Yes 2 No
tal Rec cian: The certificate ector, page	BeC	25. Was case referred to medical examiner?			26.Place of Death			
n of Vi ling Physi After this funeral dir	ို	1 ✓ Yes 2 No Inpa 27. Manner of Death 28a. Date of the		ER/Outpatient 3 28b. Time of Injury	DOA Other; 28c. Injury at Work	Nursing Home 5	Residence 6 e how injury occurred	Other:
ion C trending leath. tor: Af	ation	1 Natural 5 Pending 2 Accident Investigation	(gear)	2027 hrs	1 Yes 2	 Subject st 		
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A	Certification;	3 Suicide 6 Could not be determined (Specify) h		ome, farm, street, facto	ry, office building, e	or Town		or Rural Route Number, City ttsville, MD
To the Hos within 24 h To the Fun	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examiner: On the basis o	camination ar					
To With	Mec	29b. Signature and title of certifier	d.		9c. License number			(Month, Day, Year)
		Theolus M. 7479	This	and	O.C.M.E.	OCME	April 1, 2008	3
R(3)		30. Name and address of person who completed cause of Theodore M. King, Jr., MD. Assistant			Penn Street, Ba	Itimore, MD 212	01	
S Regis	ate	31. Date filed (Month, Day Year) APR 1 5 2008 32. Regist	rar's Signatu	Earth a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year Sylvia Louise Newman Apri1 2008 11 8:40p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) Days Months 1 □ M 2 🛛 F Yrs 77 2/16/1931 Abbeville, SC 579-40-4958 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 □ No Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1740 Albert Drive 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Black 3[™] Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elijah Reed Virginia Cade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1740 Albert Drive Mitchellville, Maryland 20721 Margaret Weaver / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2008 Lincoln Memorial Suitland, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death Due to (or as a consequence of): he 3 (Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2010 1 Tyes 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No М investigation

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or iteme 23a or 28a-f show the Mudical Examinar must be notified at

Funeral Director

Completed by

Be

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death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than try or other treumstic event, tre Mi

Baltimore, Maryland 21215-0036

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Visitionly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Physician/Medical IF FEMALE: for use 23b. Was decedent pregnant in the past 12 months? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ icate has been sig , page 2 should b Be Completed certificate funeral director, 25. Was case referred to medical examiner? Certification: To 1 🗌 Yes 27. Manner of Death 1 Aatural 2 Accident death. the ! within 24 hours after deat To the Funerel Director: 6 ☐ Could not be 3 Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 6 address of pe the completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day

APR 15

2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 12 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month **Physician** 2008 5:15p 3 24 Elizabeth Anne Ochota /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Faston
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) Talbot Talbot Hospice Foundation 9. Birthplace (State or Foreign Counting witzerla Fribourg, nd 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2√2F Yrs. 5-26-1926 246-58-8111 81 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other treumatic event, the Medical Examinat must be notified at ADR8. 10a. State 10c. City, Town or Location X⊓Yes 2□No Director St. Michaels Md Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 102 Madison Avenue 21663 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Clinic 12 years xray Technician years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alois Bapst Gertrude Noth ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dr. Leszek Ochota(husband) 102 Madison Ave., St. Michaels, Md. 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial Cremation 3 Removal from State Capitol Crematory 3-26-2008 Dover, De. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Part 1. Enter the disease, or complications that exceed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIAC FAILURE 6 hours Physician /Medical Due to (or as a consequence of): 48 hours RESPIRATORY INFECTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Examiner METASTATIC SCCA NECK 784.2 The law requires that the death certificate be executed signed by the attending physiclan and d be detached for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown YOPATHY been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Wasan s certificate has t lirector, page 2 s performed 1☐ Yes 2 No director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice House 1 ☐ Yes 2 No ဥ this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospitel or Attending Physician: erel Director: After th within 24 hours a
To the Funerel I
completely filled

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1013 S. Talbot St., St. Michaels, Md. 21663 Joseph A. Besso,

31. Date filed (Month, Day, Year) MAR 2 7 2008

29b. Signature and title of certifier

Registrar's Signature

State

Registrar

29c. License number

60300

29d. Date signed (Month, Day, Year)

Records, P.O. Box 68760 Division or Vital

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or items 23a

Director

Funeral

9

Completed

Be

Baltimore, Maryland 21215-0036 or other traumatic event, the Medical permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? **Physician** /Medical Examiner Examine attending physician and I for use as the burial-transit Physician/Medical þ Completed To the Hospital or Attending Physician: Be 2 Certification: within 24 hours after death.

To the Funeral Director: After Medical 29b. Signature and title of certifier 29c. License number 45149 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Glen Burrie 31. Date filed (Month, Day State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 = State Registrar	State o	t Mary	land / Depa <i>Ce</i>		nt of H te of L		ind Me		giené Reg. No.	2008	13778
			Decedent's Name (First, Middle, Last)								2. Date of De	ath		3. Time of Death
	Physicia /Medic		Patricia Faulkner	Price							Month 4	Day 7	2008	2:35 p M
	Examin		4a. Facility Name (If not institution, give s	treet and nu	mber)		4b. Ci	y, Town, or	Location of	f Death		4c. (County of Death	1
			Hospice Of Queen A					trevi					een Ann	
	Funeral Director		219-70-8558	M 250 F	7. Age (In 68	yrs. last birthday) Yrs.	Month		If Under 2 Hours	Min.	8. Date of Bin (Month, Da 10/5/19	th y, Year) 939	9. Bint Cou Mary	place (State or Foreign Intry) land
	pug *		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or Lo	ocation							10d. Inside City Limits
	Aaryla f eho	ō		•										1 ⊠Yes 2 □ No
	28a	Directo	MD Queen Ann 10e. Street and Number	ie s	2	udlersvi		ip Code				10g. Citiz	en of What Cou	intry?
	h with	ai D	411 S. Church St.				21	668				USA		
	deat	Funeral		12. Was Dec	edent Ever	in U.S. 13.	Was Dec	edent of Hi	spanic Orig	in? (Spec	city Yes or No		4. Race - Amer Black, White	
9500-91212	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or iteme 23s or 28s-f show afte event, the Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Gi Year or D	2 TNo ve	4		25kNo	Specify:	, , , , , , , , , , , , , , , , , , , ,	noun, oto.,			ite
, D	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece	dent's Us	sual Occupa	ition u <i>ring m</i> ost	of workin	ıg	16b. Kin	nd of Business/I	ndustry
7	ithin Jen Med	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired,	uring most	OF WORKIT	g			
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<u>8</u>	and 2 seelth arm 27 is		Lawrence Thomas Pi	cice /	son								D 21668	
ē,	item 2		20a. Method of Disposition		2	Ob. Place of Dispo	sition (A	ame of	1	/11/2	-		cation - City or T	
Ĕ	Page nent c ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from		Immanue1	-		· 1 •	metei		Ches	wold, D	E
Baltimore,	permit. Pages Depertment of the Important: If its eny injury or of once.		21. Signature of Funeral Service License	e		F	ello V	and Addres	s of Facility	bein St	& Newr			Home PA 51
			23a. Part1. Enter the disease, or compli	cations that o	aused the								FID 210	Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on	each line.	actul 1	CAN	ke/	•					Interval Between Onset and Death
ř	/Medical		disease or condition resulting in death)	Oue to	(or as a con	nsequence of):		CE						MOTIFIE
	Examiner		Sequentially list conditions, b											
	be tis	iner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a co	rsequence of):								
	and and Il-tran	Examin	that initiated events resulting in death) Last	Due to	(or as a cor	nsequence of):						_		
8/00,	cate be executed physicien and the burial-transit	aiE			(
80		edicai												
ŏ	death certif e attending id for use a	NZ.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, out			Tetania					2	3d. Date of deliv	very
ם מ	e deat	by Physician/Me	in the past 12 months? 1 Yes 2 No		ant at time		Other (pregnancy specify)					Month	Day Year
<u>ب</u>	d by ti	Phy	9 Li Unknown								U			
as,	w requires that the death certif been signed by the attending should be detached for use a:		Part II. Other significant conditions con	tributing to d		resulting in the	nderlying VVP /	cauşe give	n in Part I.		23e. Did to		No 3 Pro	the cause of death? bably 4 □Unknown
Ö	v requ been shoul	ompieted	11/10/10/10/	Dys.y		14		./-(_	-		7 - 1 - Semi-11	
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VII	iician: Th certificate rector, pag	၁ .	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes Check only o	200	1 🗆 Yes	25 160
	Physician: The larthis certificate has ral director, page 2	T0 B	examiner?	ospital:	Inpatient	2 ER/Outpatier	nt 3 🗆 (Othe	-		e 5 Resid	real file and	ther (Spec	Inputtent
0	th. After this of funeral dir		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Yea	28b. Time of Injury		28c. Injury Work	at		8d. Describe h			" requie
<u>0</u>	Attending r death. ector: After by the funer	catle	2 Accident investigation				М		es 2	6				
DIVISION	or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined		of Injury - ng, etc. (S)	At home, farm, str pecify)	eet, facto	ry, office		28	Bf. Location (S City or Tox	Street and vn, State)	Number or Rui	al Roule Number,
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one)	er: On the b	best of my asis of examer stated.	knowledge, death	n occurre vestigatio	d at the time on, in my op	e, date and inion, death	place, ar	nd due to the	cause(s) a	and manner as place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and man	ioi sialeu.		2	9c. License	number			29d. Date	signed (Month	Day, Year)
			1 m					Moul	388	-			4/8	108
	10	-	30. Name and address of person who co	npleted caus	e of death	(Item 23a) (Type,	Print)	UW I	550	,			110	03
	ma		Matthew King 1	MID.	10	10 Spec	- K	ad	Che	este	tave,	M	12/62	10
	Stat	e	31. Date filed (Month, Day Year)	2008 D	egis ar's S	ignature *	4				,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Kathryn Carol Rupert P^{M} Apri] 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 217-38-8056 1 M 200 Months Min. 65 Director 13, 1943 Feb. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: filem 27 is marked other than "natural", or items on other trainment. 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Anne Arundel Edgewater Director 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 87 Stewart Drive 21037 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes
XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. White Completed by Yes, Give Specify. 30XWidowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Thomas Kathryn Adele Hopkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie J. Tucker/daughter P.O. Box 912 Stevensville, Maryland 21666 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 4/9/2008 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Rigensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician letes Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes _ 2 🐼 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel Medical Center Annapolis, Maryland Dr. Hung Davis 31. Date filed (Month, Day, gistrar's Signatur APR 0 9 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		aryland / Dep	partment of learnificate of			Reg. No.	08	13780	
	Physici	an	1. Decedent's Name (First, Middle, La		2. Date of Di Month	Day	Year	3. Time of Death				
-	/Medic		Sylvia Mae Ruff					Apri1	7, 20		15:15 M	
	Examir	er	4a. Facility Name (If not institution, given Chester River Ho			4b. City, Town,	or Location of Death					
						Cheste		0.00		Kent		
	Funeral		5. Social Security Number 6. S	iex 7. Aα □M 21∑1F	ge (In yrs. last birthda 87 Yrs.	Months Days		8. Date of Bi (Month, D	ay, Year)	9. Birthpla	ace (State or Foreign try) Virginia	
	Director		236-32-3670 Usual Residence of Decedent				Aug.1,			1920 WESL V		
	land wo	Director	10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits	
	Mary		Maryland Queen Anne's Sudlersville									
	the 28a		10e. Street and Number 10f. Zip Code 10g. Citizen of What Co								try?	
	ours after deeth with the Marylan rat, or items 23s or 28s-f show Exercicer must be notified at	ā	961 Busic Church	Dood	.8		USA					
	TIS 2	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13	2166 Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or N		ce - America		
10	fler of the rest	ᇤ	1 Never Married 2 Married	Armed Forces'	No No			Rican, etc.)	Black, Whi Specify: Wh			
93	urs a	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specia	ce		
Õ	2 ho	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of B	Jusiness/Ind	lustry	
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2	alth alth 27 i		Frank Anthony Ruf	f /husb	and 961	Busic Ch	nurch Road	Sudle	rsville,	MD 2	1668	
Baltimore,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	TB 1/ 0	20b. Place of Dis	position (Name of ematory or other pla	ace)	Date	20c. Location	- City or Tov	wn, State	
Ĕ	Page int: if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Templeville Cemetery April 11 Templeville, MD									
Ħ	permit. Pages 1 Department of H Importent: if ite any injury or ot		21. Signature of Fyneral Service Licer	nsee		22. Name and Addr	ess of Facility				- E.	
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Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificale has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	☐Ectopic pregnand	ey			ate of deliver	ry Day Year		
σ	that led b	2	Part II. Other significant conditions of	contributing to death I	out not resulting in the	underlying cause g	ven in Part I.	23e. Did	tobacco use con	tribute lo the	e cause of death?	
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Ö	th.	<u>ā</u>	27. Manner of Death 1 Actual 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Accident investigation 28c. Injury at Work? 1 Yes 2 No									
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	a Hospitel or At 24 hours after of a Funerel Direct letely filled in by	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best niner: On the basis of and manner si	of my knowledge, de of examination and/or lated.	ath occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) and m	anner as sta , and due to	ated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	. /		29c. Licen	se number		29d. Date signe	ed (Month, C	Day, Year)	

(Final n	Renal Failure										
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batas	5			24a. Was an autopsy performed	prior to death?	Itopsy findings available completion of cause of					
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No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	DA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spe	cify)					
h 5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred						
6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factor fy)	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
1 Certifying Phy 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)					
title of certifier		29	c. License number		Date signed (Mont	h, Day, Year)					
ace of pareon who r	completed cause of death (Ite	m 23a) (Type Print)			1 0100						

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State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salons 32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Louise Remener 3:55 p ^M 8, 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 17209 Hunter Green Road Upperco If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min 1 ☐ M 2 🗹 F 165-18-2131 88 Pennsylvania Director Nov 28, 1919 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Upperco permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a Baltimore 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 21155 17209 Hunter Green Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Loan Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Martinchek Ignatius Remener 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17209 Hunter Green Road, Upperco, MD 21155 19a. Informant's Name/Relationship (Type. Print) Gina Serra, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Columbia County, PA New Rosemont Cemetery 4/12/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Testidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🖂 Inpatient ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Manual of the cause (s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

W

29b. Signare and title of certifier

Middleton 333 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Street, Manchester, MD 2/102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene . Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 11, 2008 DOROTHY MAE ROYAL APRIL 0343 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S PRINCE CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Davs Hours Min. 1 □ M 2 🕱 F 11/2/1939 Bluefield, WV Director 578-54-4749 68 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show or than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director Maryland | prince George's Laure1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with United States 186 Jill Lane # T2 20724 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, that M. Private Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Virginia B. Walker Charles Robert Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 Jill Lane # T2 Laurel, Maryland 20724 Kimberly Sanders/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2008 | Bluefield, WV Restlawn Memorial 21. Signatur f Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. M01025 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** I schemic cardiomy on the /Medical Due to (or as a consequence of): Examiner theroscierosis Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Diabeter Mellitus burial-trans and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ρ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐NO P.0. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð Metactatic breast Cuncer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed neumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page Anemia certificate 1 ☐Yes 2 ☐No 1 ☐ Yes of Vital 2 - NO or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier * ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State
Registrar

31. Date filed (Month, Day, Year)
APR 1 5 2008

WUMAN



30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

nn

00043662

HOSPITAL DRIVE, CHEVERLY, MD. 20784

4111108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HELEN REDDING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛣 F 12/22/1937 70 NORTH CAROLINA Director 578-50-8877 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State a or 28a-f show t be notified at 10b. County 1X Yes 2 No MD PRINCE GEORGES MT. RAINER Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2416 ARUNDEL ROAD 20712 USA ral", or items 23a Examiner must b Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" er than "natur, the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene.
ht: If item 27 is marked other than ", ry or other traumatic event the Mean Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 10TH FOOD SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT REDDING BLANCHE BOYD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 ARUNDEL ROAD MT. RAINER, ADA BOWLDING/DAUGHTER MD 20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK 04/12/2008 LANDOVER, MD 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL ROME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an page 2 certificate 1∐ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 211 1 npatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

law requires that the death certificate be executed Box 68760. P.0. this

Maryland 21215-0036

Baltimore,

After thi funeral

Division or Vital Records, or Attending Physician: death. within 24 hours after death

To the Funeral Director:
completely filled in by the 1

State Registrar

Certification:

Medical

1 Natural

2 Accident

3□ Suicide

4 Homicide

29a. Certifier 1🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year)

MDD60611

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of death (Item 23a) (Type, Print) 30. Name and address of pe

8118 Good Luck Rd, Lunham

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

Lynn Edward Sipe,			tate of Maryl		Departmen	t of H	lealth and				gible.	200	18 1378
		Registrar 1. Decedent's Name (First, Midd	llo Last\		Certificate	of L	eatn		121	Re Date of Dea	eg. No.		3, Time of Death
Physician Medical Examine	er	LYNN EDWARD SI	PE, III						Į.	Month April 4, 20	Day 108	Year	1503 hrs
A second	•	4a. Facility Name (if not institution Augustine Herman H		,	orner Rd		City, Town, or L Salena	ocation of D	eath		4c. Co Ker	ounty of Dea nt	ath :
Funeral	T	5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	** -	f Under 1 Year	If Under 24		. Date of Bir	th(MM/DD		Birthplace (State or eign
Director		219-86-6143	1 X M 2 F		32	Yrs.	Months Days	Hours	Min.	MARCH	1,19	76	Countr MARY LAND
âu	_	Usual Residence of Decedent 10a. State 10b. County		Tin	c. City, Town or I	ocation							10d. Inside City Limits
<u>*</u>	١		CIL		, o. o.,, . o o	2004(101)	CECILT	'ON					1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at onc	3 -	10e. Street and Number			10f. Zip Code					1	0g. Citizer	of What Co	ountry?
tith the Maryland 23a or 28a-f show notified at once.	5	226 EAST MAIN STREET			21913						UNI	TED S	TATES
with ms 23 be no	<u>a</u>	11. Marital Status	12. Was De		ver in U.S.		ecedent of Hisp specify Cuban,				- 14	. Race - Am White, etc.	erican Indian, Black,
r death v	5	1 Never Married 2 X N	1 Yes	2 X	No				ierto Ric	an, etc.)		τ	VHITE
ural",	⋧┞	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Ye or Dates:		eted) 16a Dec		es 2 No		of work	done		ecify: of Busines	
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5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar	Ē		1			DIRE	CTOR OF	SALE	S		MANA	GEMEN	T
21215-0036 and be filed within 7 Mental Hygiene. marked other than evernt, the Medica		17. Father's Name (First, Middle LYNN EDWARD SI						8.Mother's N			Maiden Su	rname)	
212 ould bould bd Ment s mark	5	19a. Informant's Name/Relation	ship (Type, Print)			-	ddress (Street						
MD and 2 sho m 27 is aumat		EMILY TARRANT 20a. Method of Disposition	SIPE/WIFE	1	226 20b. Place of D								ND 21913 or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in Pages I and 2 should be filed within 12 hours attural", or items 23a or 28a-f she important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director		Burial 2 Cremation Donation 5 Other S		from State	GLEN HA PARK	VEN	MEMORTA	L A		12, 2008		·	IE, MARYLAND
Balti permit. Departn Imports		21. Signature of Funeral Service		M00	0672	22 Nam CREM ROAT	e and Address of ATION A ANNAP	of Facility F	L KA	WS CAR	ELFEN 2140	BEIN A., 8	LA NEWNAM 14 BESTGATE
Physician	+	23a. Part i. Enter the disease, o		caused the									Approximate Interval Between Onset and
/Medical xaminer	ı	failure. List only one cause Immediate Cause (Final disease	B. A. alekan Land	juries									Death
		or condition resulting in death)	Due to (or as	a consequ	uence of):								
1		Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	uence of):								
ed nsit Examiner		cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as	a conces	iones of):								
		events resulting in death) Last	d	a consequ	derice or).								
be execu- sician and urial - tra	5	UNPENDED	AMENDED										
Box 68760, see death certificate be the attending physical for use as the burnes is the burnes of the burnes of the see the burnes of the burn		IF FEMALE: 35. Was decedent pregnant in t	ho -	, outcome birth	of pregnancy	Fetal	death 3	Ectopic pr	egnancy	,		Date of deliver on the contract of the contrac	rery Day Year
× 68 th certi		past 12 months?	4 Preg		ne of death 5	=	(Specify)		ognanoy		"	on	Day (oa)
). Bo) the death by the att	2			nown						100 - Dista			1- H 6 1
cords, P.O. B law requires that the d has been signed by the 2 should be detached	3	Part II. Other significant condi	tions contributing	to death b	out not resulting in	the und	eriying cause gi	ven in Part i	•				to the cause of death?
Records, The law require: ficate has been sig., page 2 should be	Bal						•••		_	24a. Was		24b. Were	autopsy findings available
tal Records ian: The law requi certificate has been ector, page 2 should	를							·			ormed?	prior t death	to completion of cause of ?
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Vital Vital hysician this cert	۱۵	examiner? 1 Yes 2 No	Hospital: 1	Inpatient	2 ER/Outp	atient 3		Mh an -		lome 5	Residenc	e 6 🗸 Ot	her: Scene
of \langle of \langle ing Phy	- 1	27. Manner of Death	28a. Dat	e of Injury	28b. Tim	ne of Inju	ry 28c. Injury	y at Work?		d. Describe			
ion tendir eath. tor: A	<u> </u>		ding Apr 4,	th Day,Year 2008	" 1503 h	rs	1 Ye	es 2 🗸 No	, U	iver auto	auto co	ilision	
Division of Vital Records, spital or Attending Physician: The law requir nours after death. real Director: After this certificate has been s filled in by the funeral director, page 2 should to Complete the contribution. To Re Complete the		3 Suicide 6 Cou	ld not be 28e. Pla	ce of Injur	y - At home, farm	, street, t	actory, office bu	uilding, etc.		or Town,	State)	Number or hway , Ga	Rural Route Number, City
Hospi 24 houe Funer cely fil		29a. Certifier 1 Certifying F	hysician: To the beaminer: On the basis	est of my k	nowledge, death	occurred	at the time, dat	te and place,	, and du	e to the cau	se(s) and r	manner as s	tated.
To the within 2 To the complet	┋├	29b. Signature and title of certifi	and manner	stated.			29c. License						Month, Day, Year)
. 1		Money C	mulhi 6	人			O.C.N	Л.E.				5, 2008	
KAW	\	30. Name and address of person	n who completed car	use of dea	th (Item 23a)						1		
Mark		Margarita Korell MD.	Assistant Me			11 Pen	n Street, Ba	Itimore, N	MD 21:	201			
State Registra	_	31. Date filed (Month, Day, Year APR 0	9 2008 32.5	Registrar's	Signature	1	e Marie						
DHMH 17 Rev 1/2001					ORIG	INAL			-				ocase OGME

Certificate of Death

)	Physiciar /Medica Examine					
	Funeral Director					

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and buriat-tran for use been signed by the a should be detached page 2 should funeral director,

Division or Vital Records, P.O. Box 68760,

WJL

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2008 April 7, 2:30 p Susan Ann Shaffer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Westminster Carroll Hospice Dove House 8. Date of Birth (Month, Day, Year) June 13, 1953 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🗷 F Maryland 218-62-0962 54 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Carroll Westminster Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21157 58 Pennsylvania Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Bus Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Murray Norris Alexander ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Stone Road, Westminster, MD 21158 Bradley E. Shaffer, son 20b. Place of Disposition (Name of Southly, crematory or other place)
Carroll Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/12/2008 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Sigrature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 ustic K. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 □ No 3□ bably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an 1□ Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif son who completed cause of death (Item 23a) (Type, Print) 30. Name and address 32. Registrar's Signature Year. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 9, 2008 **Physician** John Harold Sanders 5:31 a м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westminster Carroll Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**™** M 2□ F 69 215-36-0219 Aug 12, 1938 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Westminster any Injury or other traumatic event, the Medical Examiner must be notified Director Maryland Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 602 Oneta Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
U.S. Dept of 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture District Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Isabel Chambers James William Sanders ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Oneta Drive, Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Janet Marlene Sanders, wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Junior Order Cemetery 4/13/2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Preston, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 ستلمي 23a. Part1. Enter the disease, or complications that caused the stath. shock, or heart failure. List only one cause on cach line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imme late Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

WSL 10

DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and

title of certifier

31. Date filed (Month, Day, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

enterStreet Westminister

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

4/11/08 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Rohan Rengen, DO 400 West 7th Street, Frederick, Maryland 21701 32. Registraris Signature 31. Date filed (Month, Day, Year) State 2008 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Year 543pM 2008 E. Maxine Sellers 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Doctor's Community Hospital Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Min 1 ☐ M 2 💢 F Yrs. 224-48-0178 March 3, 1924 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ∑Yes 2 No Prince George's Maryland | Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 619 Castlewood Drive United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2★☐ No Specify: Specify. 3₺ Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Clerk Private 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Martha Fergusson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 619 Castlewood Dr. Upper Marlboro, MD 20774 Norma Frazier Yates - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Lee's Crematory 4 / 17 / 2008 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) noumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated events. Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown

Physician /Medical Examiner

Health tem 27

permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once.

Baltimore,

Physician

/Medical

Examiner

Funeral

Director

Show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Funeral

Completed

Be

2

with the Maryland

Completed by Physician/Medical

Examiner

Be

Certification:

attending physician and for use as the burial-trar spital or Attending P nours after death, neral Director; After i y filled in by the funera

Division or Vital Records, P.O. Box 68760,

Part II. Other significant conditions o	ontributing to death but not resulting in the underlying caus	se given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown									
			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check only one)											
examiner? 1 Yes 2 No	Hospital: 1 ∏ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	ome 5 Residence 6 Other (Specify)										
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury	occurred								
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, o building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
	ysiclan: To the best of my knowledge, death occurred at niner: On the basis of examination and/or investigation, in											

D45660

29d. Date signed (Month, Day, Year)

4-10-08

(N, 124 Bacie MD Ze)11

State

31. Date filed (Month, Day, Year APR 1 5 2008 **APR 15**

300,

29b. Signature ar

LA

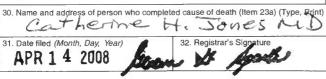
person who completed cause of death (Item 23a) (Type, Print)

Registrar

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 1 4 2008



Johns Hopkins Hosp. 600 N Wolf St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra MFND#1perMD4-18-08, BMV, MCCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) STEPHEN 2. Date of Death Time of Death TUTWILER Month Dav **Physician** 4/10/2008 Steven Tutwiler 10:15 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 3120 Pheasant Run I jamsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 X M 2 □ F West Virginia Director May 28, 1954 234-84-7252 53 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Frederick Ijamsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21754 United States 3120 Pheasant Run Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cleaning Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked o Department of Health and Men Important: If item 27 is marker any injury or other traumatic George S. Tutwiler Georgia O. Shahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17826 Cricket Hill Drive, Germantown, MD 20874 Lilana Loether-Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-17-2008 Brentwood, MD 9 22. Name and Address of Facility Simple Tribute 21. Signature of Huneral Shrvice License 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Esophageal Varices /Medical Due to (or as a consequence of): Examiner Advanced Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and the burial-transil Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Severe Venous Insufficiency Both Legs 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has page 2 No 1□ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ဥ 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mapner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation injury 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: ours after death.
neral Director: A within 24 hours a To the Funeral I ompletely

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00026900 April 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD; 6225 Mazwood Road, North Bethesda, MD 20852 MD; Blaylock, Barbara L.

State Registrar

6

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Diane C. White A^{M} 2008 2:35 April 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death **Examiner** Anne Arundel Annapolis 2 N. Cherry Grove Avenue If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F 219-38-9802 65 Yrs Director May 15, 1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-4 ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifiled at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 U.S.A. 2 N. Cherry Grove Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any injury or other traumatic across once. Financial Services Insurance 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bernhard Clatanoff Rebecca Eugenia Medford 2 19a. Informant's Name/Relationship (Type. Print)
Barbara J. Lord/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 Broadview Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore Crematory 4/8/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONCER OF LYRS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other alguificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed? 2 X No the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 22 No Hospital: Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie BANIL 8 D0811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PONNAPULIS MA 21401 900 TEATE AD TANVERY 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar APR 0 9 2008

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

APR 1 4 2008

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** APRIL 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS 5. Social Security Number Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Yrs. Director 579-92-3437 38 NOV. 20 1969 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 51ST STREET 20019 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: BLACK 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) vr Musician Private marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finand Mental F Richard E. Williams Peggy J. Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health a Carlena Briscoe-Williams/Wife 513 51st St. N.E. Washington, DC 20019 permit. Pages 1 s
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 4/15/2008 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 21. Signature of Fundari Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between aset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) hour /Medical Due to (or as a consequence of): Examiner tailur if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Kle 15lase and burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9☐Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t director, page 2 s autopsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral Manner of Death 28a Date of Injury 28h. Time of 28d. Describe how injury occurred Certification: eral Director: After filled in by the funer (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after or To the Funeral Direct 4 Homicide after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

Medical Doctor

RES - 000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street, Baltimore, Maryland Elizabeth Lenderman

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 5 2008

			State of Maryland / Depar	tment of Health and Mificate of Death	lental Hygid		13796
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
~	/Medi	cal	Leonard Williams		April 9,	2008	18:30 M
	Exami	ner		4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Prince George's Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	
	Director		_ 579-58-2353 1□ M 2□ F 67 Yrs.	Months Days Hours Min.	(Month, Day,) Sep 9, 19		place (State or Foreign ntry) Sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca				
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	er death with the Marylan tems 23a or 28a-f show mrust be notified at	Director	Maryland Prince George's Capitol He	ights 10f. Zip Code	100	g. Citizen of What Cou	
	th with	al D	5024 N. Englewood Drive	20743		Inited Stat	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever in	is Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,	an Indian,
36	ours afte ral", or i	by F	1 Never Married 212 Married 1 Yes 212 No	Yes 2√∑No <i>Specify:</i>	, mount, orany		ack
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Evan.		15. Decedent's Education 16a Deceden	nt's Usual Occupation	16	b. Kind of Business/In	
215	- 0	Completed	(Specify only highest grade completed) (Give kir Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of working NOT use retired)	ng	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	audit y
	be filed withii ntal Hygiene. nd other than event, ne.	S	12 years Auto	motive Analyst		Governmen	t
and	ould be fil Mental H arked otl atic even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Surname)	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the manatic event events eve	ဍ	Leonard Williams, Sr. 19a. Informant's Name/Relationship (Type Print) 19b. Mailing	Bernice		20 - T	
Ma	nd 2 salth ar 27 is r trau			Address (Street and Number or Rura ${ m N}_{ullet}$ Englewood Dr.			
Baltimore,	ges † and 2 should it of Health and Mer if item 27 is marke or other traumatic	1 3	20a. Method of Disposition 20b. Place of Dispositi			c. Location - City or To	
Ë	Page ment ant: II ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematical Crematical Company		3	Clinton	. MD
3alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lidouse 22. N	lame and Address of Facility Ste	wart Fun	eral Home,	Inc.
		H		001 Benning Road,			20019
	Physician /Medical Examiner	ler	23a. Part Lanter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause. Enter Underlying	Marion waron	respirato variesi	e	Approximate Interval Between Onset and Death
68760,	Hospital or Attending Physician: The law requires that the death certificate be executed thous after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical Exam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.				
P.O. Box (t the death certifica by the attending ph ached for use as th	Physician/Med		ctopic pregnancy ther (specify)		23d. Date of delive	ery Day Year
Records, I	re law requires that the de has been signed by the a ge 2 should be detached for	þ	Part II. Other significant conditions contributing to death but not resulting in the unde	rlying cause given in Part I.		cco use contribute to the	
Vital Rec	ding Physician: The law n. n. After this certificate has t funeral director, page 2 s	e Completed	25. Was case referred to medical			prior to con	osy findings available inpletion of cause of 2 No
ί	ysicia is cer direct	m	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death Other: 4 \(\triangle \text{Nursing Horn}\)		e 6 □Other (Specif	
n of	ng Ph fter th neral	Certification: To	27. Manper Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		8d. Describe how i		<u>//</u>
sio	tendii eath. or: A the fu	catic	a Accident investigation 3 Suicide 6 Could not be	M 1 □Yes 2 □No			
Division	or At after d Direct in by	Ë	4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office 2	8f. Location (Stree City or Town, S	t and Number or Rura State)	Route Number,
_	spital ours a neral filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death or	payred at the time, date and place			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) edical Examiner: On the basis of examination and/or invessional manner stated.	tigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complete	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	1		1 Salemen ons.	130318	\	110/08	>
P	(4)	1	30 Name and address of person who completed cause of death (Item 23a) (Type, Prin	1 - 1 1 7 0	00 %	600	2000
	Star	· .	31. Date filed (Month, Day, Year) 32. Registrar's Signature	HOSPITAL UR.	hever	4 mo	20183
	Registra	ır	APR 1 5 2008 Seem & Aparles				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ORMA WELSH 2205 2008 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 6-2-1935 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 € F 577-44-8981 Director Durham, NC Usual Residence of Decedent with the Maryland a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Calvert Prince Frederick 1 X Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a c 4320 Cassell Blvd. 20678 United States Pages 1 and 2 should be filed within 72 hours after death wment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: \$ 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Peerless Blue Mattie Ellen Lynn ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura J. Brady (Daughter) 4320 Cassell Blvd. Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ott once. 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4/14/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify)-22. Name and Address of Facility Fort Lincoln Funeral Rome 21. Signature of Fyne al Sarvice Licensee 3401 Bladensburg whil Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician ai disease or condition resulting in death) /Medical Due to (or as a conse yence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 s this certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 6 Sother (Specify) MANDRIN Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred HOSPICE HUGE 5 ☐ Pending investigation 1 Tes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical and manner stated. 29b. Signature and title of certifier te signed (Month, Day, Year) 30. Name and address of person who cor ted cause of death (Item 23a) (Type Print)

DHMH 17 Rev 1/2001

State

Registrar

MICHAEL J.
31. Date filed (Month, Day, Year)

2008

32. Registrar's Signatu

EFENSE

Registrar DHMH 17 Rev 1/2001

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within 24 ho

To the Function

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 2 8 2008

Medical

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANE, F. N. DOLARUM, MD 196 TJ DRIVE, FREDCHICE, HD 24703

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00062223

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year EARL STEVEN ASKINS 702 PM APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE STELLA MARIS TIMONIUM Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min 215-54-2657 58 MARYLAND Director 00035223 1944 Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD RANSALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA LIBERTY ROAD Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: WHITE 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME INPROVEMENT DISPATCHER 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNA CORBIN EARL ASKINS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a BRINLEE BROADCH LANS MCKNUEY, TX 75071 REBECCA WEST 10 AUGHTER 2516 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 iof P Date permit. Page Department of Important: If any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JATOMY GIFTS RELUSTRY APRILAY DOOR HANOWER 4 Monation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ANATOMY GIFTS PELISTING 7503 COUNELLEY DRIVE, STE P. HANDWIR, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) RECTAL CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2 No 1 □ Yes 2 🗆 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOSPICE 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation spital or Attendi nours after death. neral Director: A / filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 52 30. Name and address of person who completed cause of death litem 23a) (Type, Print) DR, ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

27,

State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Richard Anderson 6:14 A M 26, April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8008 Harris Avenue Parkville Bal timore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days 126-18-0856 12 M 2 □ F Director Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov 72 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it is rectain Examine to all to notifie or 1 □Yes 2 No Director tarkvill altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) echnician nevion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev ပ Anderson atherine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pertrude Hinder 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, 2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral, Service Bultimore, MD 212 Kunker Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Evans Funeral Chapeta Cremation Services Parkville Approximate Interval Between Onset and Death Immediate Cause (Figure disease or condition resulting in death) Physician a CBREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been significate has been significated by page 2 should by Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate | 2 No Division of Vital 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:

completely filled in by the i 3 Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-28.08 121022 malin

DHMH 17 Rev 1/2001

State

KUNALEWSKI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BACTU. MD. 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 1 CON ARd 25 3:10A M /Medical Facility Name (If not institution, give street and number)

ALT, mole, VA Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death ALTIMOR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 10-M 2□ F Days 217-26-8716 Usual Residence of Decedent Director 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 10d. Inside City Limits Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours after death with artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be 1 21239 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Tyes 2 No I Yes, Give ear or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 9 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ransportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paltimore, MD 21239

Date 20c. Location - City or Town, State Sagra clizabeth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Deurial 2 Cremation 3 Removal from State 50N Forest 5.2.2008 Baltimore Mi)
22. Name and Address of Facility 4905 York and Baltimore, MD Important: I any Injury o Garrison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Vaugno C. Greene Funeral Services 21212 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Schemi **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Duy to (or as a consequence of): burial-t P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ å 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation Injury thin 24 hours arren con the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 20 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 10 North GREENCST BALLIMURE, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2:30 A™ /Medical ne (If not institution, given Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore vursing ttome. 6. Sex If Under 24 Hrs. A. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 3. 12. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 F 66 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the MacLical Evantment and be notified at once. Director 1 **Y**es 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life) DO NOT use ratired) College (1-4or 5+) antress Be Father's Name (First, Middle, Last ပ 19b. Mailing Address (Street and 20b. Place of Disposition (National Company) nod of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CA **Physician** SON /Medical Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exami burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Š in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 □ Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes 2 ER/Outpatient 3 DOA P within 24 hours after deau.

To the Funeral Director: After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature nd title of certifie ျှ 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000sl Woods 31. Date filed (Month, Day, Year) 32. Registrar's Signature State A CAR 9

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM 31 periods 03/8 4/29/08 WS

State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Salvatore James 2^Y008 Brocato April 1:04 a^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5407-A Old Frederick Road Baltimore Baltimore 5. Social Security Number Sex 1M 2□F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APR 18 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 218-26-9385 Director 76 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f si the Medicel Examiner must be notified Director MD Baltimore 1 ☐ Yes 2 N No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 5407-A Old Frederick Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s any injury or other traumatic event. The Maritest Events by Funeral 21229 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Letter Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Vincent ပ္ Brocato Carmella Marie Geppi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Brocato - wife 5407-A Old Frederick Road, Baltimore, MD 2122 ace of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 4/28/2008 Baltimore, MD 21. Signature of Funeral Service Licensee H 22 Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause out ach line. Approximate Interval Between iterval Be... Inset and Deati Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s 24a. Was an performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D24781 28,2008 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of O_f

State

State Registrar 1001 PINEHEIGHTS AVE #300
31. Date filed (Month, Day, Year)
32. Registrar's Spinature

32. Registrar's Signature

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as so promes

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year <u>Malcolm</u> 4:32p <u> Herbert</u> 2008 /Medical <u>Beers</u> pril 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Bowie Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | June 22 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 6. Sex 1 → M 2 □ F **Funeral** Months Director 83 <u> 116-16-1567</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examination is without an 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2X No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12323 Rambling Lane 20715 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive Repair 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Taylor ပ Η. Beers Maude 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Beers - wife 12323 Rambling Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
D. partment of
Important: If it
any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/28/2008 21. Signature of Funeral Service Licensee H. Cremation Society of Maryland, .Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence 1): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed sician and burial-trans a onsequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death signed by the atte 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the Underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) -To F Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending ithin 24 hours after death.

o the Funeral Director: Aft

ompletely filled in by the fun 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26492 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D. 4000 Mitchellville Rd. Bowie, MD 20716 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:40 A M Apri 25 2008 Eugene Blackmore, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore n/a 8. Date of Birth (Month, Day, Year) DEC 1 1930 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Days Months Hours Min South Carolina 215-24-1188 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 X Yes 2 ☐ No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a o iner must be 720 Richmond Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or item Medical Examiner 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monce. 12 Developmentally Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 lent of Health and Mental I Eugene Blackmore, Sr. Martin Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Stafford - sister 3040 E. Federal Street, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/26/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD 21. Signature of Funeral Service Licensee Steven, H Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amiodarone **Physician** 71 week /Medical Due to (or as a consequence of): **Examiner** Tuchycardia praven bia equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sick Sinus burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient 2 fter this Funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours a er death. Certification: 1 Natural 5 ☐ Pending investigation within 24 hours all er ueau...

To the Funeral Director: AP 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Vital Records, P.O. Box 68760, ō Division

Registrar

29b. Signature and title of certifier

Melanie

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

M.D.

29c. License number

AT 2438946

Union Memorial Hospital, MD.

29d. Date signed (Month, Day, Year)

April 25 2008

and manner stated.

mo

RIOR 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a-f show ral", or items 23a or 28a-f sh Examiner must be notified within 72 hours after Baltimore, Maryland 21215-0036 "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical

Physician

/Medical

Examiner

MD

Director

Funeral

Director

Physician /Medical Examiner

be executed

Box 68760;

P.O.

Division or Vital Records,

sician and burial-transit attending physician the use as for ed by the a detached f signed by to peen page 2 has director, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely tilled in by the funeral dir this

Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martins Marietta Machinist 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Schlicht Martin N. Bauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Bauer /wife 816 Arncliffe Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 4/28/08 Baltimore MD 21. Signature of Piner Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 ications that caused 23a. Part L. Enter the disease, or co shock, or heart failure. List on Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Much Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resuming in death.) Last Examine Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 A16 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 fedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Essex Medical Center 404 Eastern Blvd. 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Debra Bittner	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2008	380			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year				
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death				
	400 Gateshead Court Edgewood Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Sta	te or			
Funeral Director	217-88-4465 1 Months Days Hours Min. Feb. 12, 1963 Country) M				
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ne Maryland or 28a-f show any fired at once.	MD Harford Belair 1 □ Yes	2 X No			
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Baltimore, MD oemit Pages I and 2 sho Department of Health and Important: If item 27 is nijury or other traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)				
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Balt permit. Departi Import injury	21. Signature Funeral Secretarious Connelly Funeral Home of Essex 212.	MD 21			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approxim	nate Interval			
/ /Medical .xaminer	Immediate Cause (Final disease a. Asphyxia	Death			
	or condition resulting in death) Due to (or as a consequence of): b. Aspiration Of Food Bolus Complicated by morphine intoxication				
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Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	Accident Investigation Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route North State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route North State) 28f. Locat	lumber, City			
ospital i hours uneral ly filled					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	293. Certified 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
F \$ F S B		ear)			
─ ,	Panth Touchall, MD O.C.M.E. April 25, 2008				
4	30. Nartie and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
State					
Registrar	APR 2 9 2008 Julian 10 19				

State of Maryland / Department of Health and Mental Hygiene

		. '	1 - For State Registrar	Cei	rtificate of D	eath		leg. No 2 0 0 8	13808					
卷	Physici		1. Decedent's Name (First, Middle, Last) Charles William Berg Sr.				2. Date of Dea April	1 ^{99y} 2008	3. Time of Death 8:00 pm					
5	/Medic Examin		4a. Facility Name (If not institution, give street and number) 407 Kingwood Rd.		4b. City, Town, or L Anne Aru			4c. County of Death Anne Arundel						
1 mm	Funeral Director		217-40-8481 ¹™ 2□F 65	s. last birthday) Yrs.	Months Days Hours Min (Month, Day Year) Country)									
	aryiand 21215-UU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		Usual Residence of Decedent 10a. State 10b. County Anne Arundel 10c. County City, Town or Lo Linth:	cation icum			10d. Inside City Limits 1 ☐ Yes 2 ☐No							
	ath with the 23a or 28aust be not	Funeral Director	10e. Street and Number 407 Kingwood Rd.		10f. Zip Code 2109			10g. Citizen of What Country? USA 0- 14. Race - American Indian,						
036 urs after de	urs after de al", or Items Examiner m		11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 □ No If Ves, Give Year or Dates: 196		Was Decedent of His If Yes, specify Cuban 1 □ Yes 2□No	panic Origin? (Spe , Mexican, Puerto Specify:	Rican, etc.)	Specify: Cat	e, etc.					
1215-0	vithin 72 ho sne. :han "natur ie Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) mbly Worke	uring most of worki	ng	16b. Kind of Business/						
and 2	ld be filed v lenta! Hygie ked other t ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Irvin Robert Berg Sr.	11000		18. Mother's Name	(First, Middle, lary Tri	Maiden Surname)	-					
Baltimore, Maryland 21215-0036	ss 1 and 2 shou of Health and M Item 27 Is mar other traumat		19a. Informant's Name/Relationship (Type. Print) Lynda D. Berg - Wife	407	Kingwood	Rd. Lir	thicum,							
limore	t. Page rtment d rtant: If rjury or		4 Donation 5 Other (Specify)	eadowri	osition (Name of matory or other place dge Memori	ial Apri		Severna Par	ck MD					
Bal	permit Depar Impor any in		21. Signature of Funeral Service Siscensee 23. Firt1, Enter the disease, or complications that cause "the de	OBIL		ır Spring	Rd. A	Funeral Homo Arbutus, MD	21227					
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a consequence of).										
68760,	rificate be executed in physician and as the burial-transit	cal Examiner	that initiated events resulting in death) Last C. Due to (or as a const	equence of):	nce of):									
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed to death. The certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant in the past 12 months? 1 □ Live birth 2 □ Femant at time of 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year					
rds, P.	equires that en signed by ould be deta	ed by Ph	Part II. Other significant conditions contributing to death but not re	_	inderlying cause giver	n in Part I.	23e. Did to	obacco use contribute to res 2☑No 3□Pr	the cause of death?					
al Records,	: The law re cate has be , page 2 sho	Completed by	HYPERTENSION HISTORY DE CEREBRONE	KCULA	x ACU	DENT	24a. Was a autop perfor 1□ Yes	rmed? prior to death?	ntopsy findings available completion of cause of					
Division or Vital	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to a completely filled in by the funeral director, page 2 to a completely filled in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner? 1	28b. Time o	of 28c. Injury	4 LI Nursing Ho	me 5 Resid	ne) dence 6 □Other (Spe now injury occurred	cify)					
Divis	tal or Atters der salter der salter der salter der salter der salter der salter	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or Ru nn, State)	ural Route Number,					
	To the Hospital or within 24 hours afte for the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my keep control of the basis of examination and manner stated.			inion, death occur	red at the time,		to the cause(s)					
•	P P S		29b. Signature and title of certifier A12) om 220\ /T	DS				22, 2008 E-6					
	o † Sta	to.	30. Name and address of person who completed cause of death (It		BALT (MORE	NI NY	D 2/2:	2-6					
	ات Registi		APR 2 9 2008 Magaza		Right 2									

Ö ۵. Division or Vital Records, Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 29 ORIGINAL

State

	4.50		1- State of Maryland / Department of Certificate		Re	g. No. 2 U U Ö	13810			
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Mary Ann Bittar		2. Date of Death Month April	Day 2008	3. Time of Death 10:15 a M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Tov	vn, or Location of Death	Vhiir	4c. County of Deat	h			
		H		SON	0.5.4(5:11	Baltimor				
Alexander	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y 171-16-8147 89 Yrs. Wonths D	/ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Oct. 1,	1918 New	nplace (State or Foreign untry) Jersey			
	yland now at		10a. State 10b. County 10c. City, Town or Location	·			10d. Inside City Limits			
	e Mar Ba-f sh stified	ctor	Md. Baltimore Towson				1 ☐ Yes 2 ☑ No			
	with the	Funeral Director	10e. Street and Number 10f. Zip Co	^{de} 204	10	g. Citizen of What Co USA	untry?			
	death	nera		t of Hispanic Origin? (Spe Cuban, Mexican, Puerto I	ecify Yes or No-	14. Race - Ame Black, White				
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	No Specify:	Thous, oto.,		Uhite			
ה	n 72 h I "natu edical	ete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work of life. DO NOT use if	occupation None during most of working etired)	ng 1	6b. Kind of Business/	ndustry			
7 7	d withi giene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) +3 Homemaker			Own Home				
מנומ	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Surname)				
7	should nd Mer marke matic	ပ္	Anis Abd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S.	treet and Number or Rura		City or Town, State, 2	in Code)			
, Ma	and 2 sealth ar		Dr. George D. Bittar/ Son 13009 Jer	ome Jay Driv						
2	ges 1 at of He If item or oth		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name cemetery, crematory or other			Oc. Location - City or				
Daithior	artmen artmen ortant: Injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee/) 22. Name and A			Pikesvill	e, Md.			
0	Department of the concession o		Ruck 1050	ddress of Facility Towson Fund York Rd. Te	eral Hom owson, M	e, Inc. d. 21204				
H			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode o shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. prevmouia				5 days			
	Examiner		Due to (or as a consequence of): brouchiectas is				20 years.			
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Alzhei mer's disca	YC @			20 years.			
 ን.	execute and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				10 9 01-			
0/00,	ificate be executed g physician and ss the burial-transit	edical								
0			IF FEMALE: 23c. If yes, outcome pf pregnancy	- ·						
מכא	death c	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (special december 2) Other (special december 2) Other (special december 2)			23d. Date of deli Month	very Day Year			
į	at the c by the	hysi	9 Unknown							
cords, I	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying caus cougestive heart discase	e given in Part I.	23e. Did toba	acco use contribute to	the cause of death? obably 4 Unknown			
ב ב	e law ri has be	Completed			24a. Was an autopsy	prior to o	topsy findings available completion of cause of			
וומו	n: The fficate or, pag		25. Was case referred to medical			No 1 ☐ Yes	2 □ No			
	iysicia iis cert directe	ro Be	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death Other: 4 Jursing Hon		ice 6 ⊡Other <i>(Spe</i>	cify)			
	ing Ph	on: T	1XNatural 5 ☐ Pending (Month, Day Year) Injury	Injury at Work?	28d. Describe how					
	Attend death ector: ,	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, of building, etc. (Specify)	1 ☐ Yes 2 ☐ No ffice 2	28f. Location (Stre	eet and Number or Ru	ral Route Number.			
2	tal or / s after al Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	,			
	Hospi 24 hour Funer itely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at to the properties of the properties	he time, date and place, a my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)			
	To the within 2 To the comple	Mec	29h Signature and the of certifier	cense number	29	d. Date signed (Monti	n, Day, Year)			
			> (/ Ma (· V / llit mo	0034193		4/28/200	8			
	· 5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter (Bel Hsos MD 10755 Fulls Rog)	d # 700	Cuthen	ville, Mi	21093			
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 9 2008							

		_	For	State of Mar				lental Hygi	ene	10011	
		_	State Registrar		Cei	rtificate of	Death		g. No.	13811	
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Betty An					2. Date of Death Month April 24	Day Year 4, 2008	3. Time of Death 3:50 P	
The state of	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th	
and a			8518 Wind Dance W			Colu			Howard	V 1000	
	Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	x 7. Age ('In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, gust 29,	Year) Co	thplace (State or Foreign puntry) laryland	
	p.		Usual Residence of Decedent	T	0c. City, Town or Lo			(6)		10d. Inside City Limits	
	laryla shov	5	10a. State 10b. County Maryland Baltin		Owings					1 □Yes 2 No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Hem 27 is marked other than "natural", or Hems 23a or 28a-f show other traumatic event, the Modical Experient must be notified at	Director	Maryland Baltin 10e. Street and Number	iore	Owings	10f. Zip Code		10	g. Citizen of What Co	ountry?	
		a D	5 Lingate Road			2111	7	Ψn	ited State	s ofAmerica	
	ems 2	Funeral		12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am-		
36	s after , or the	by Fu	1 Never Married 2 Married	1 □Yes 2 √ No If Yes, Give X		1 □Yes 2 X No	Specify:		Cassifu	ite	
21215-0036	hours tural'	ed b	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business		
215	en "na In "na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing			
212	d withii giene. er than , the M	등	Elementary/Secondary (0-12)	0	Home	Maker			Own Home		
pu	12 should be filed w h and Mental Hygie 7 Is marked other ti fraumatic event, In	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M M - + b	laiden Surname)		
yla	d Mer narke	ပ္	Edward Milton Gu		405 14-15	- Address (Chrost	Ima N.		City or Town, State,	Zin Cada)	
Maryland	d2st Ith and 17 is n traur		19a. Informant's Name/Relationship (7) Bruce G. Behr	(Son		-			Maryland 2		
ē,	s 1 and 2 f Health Item 27 i		20a. Method of Disposition		20b. Place of Dispo cemetery, cree				20c. Location - City or		
Ë	Page nent o int: if iry or		tropy Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Druid Rid		1	0/08 P	ikesville,		
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		21. Signature of Funeral Service Incens	9 00	22	2. Name and Addre	ss of Facility Ori	ng Byers	Funeral I	irectors,Inc	
	207 29		Joseph y !							21133-4784	
			23a. Part 1 Enter the disease, or complete, or heart failure. List only o	1			ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	a Breas	consequence of):	cer				monrus	
.*	Examiner			Due to (or as a	consequence on.						
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	ecute and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
8760,	cate be executed physician and the burial-transit	alE		Due to (or as a	sonsequence or,						
687	ificate g phys as the	edical		d							
Box	eath certifit attending p for use as	M/us	23b. was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		☐ Ectopic pregnanc	ev.		23d. Date of delivery		
	or Attending Physician: The law requires that the death certific death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 1% menths? 1 □ Yes 2 IX No 9 □ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown		Other (specify)			Month	Day Year	
P.0	res that the de signed by the a be detached		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
of Vital Records,	uires t signe Id be	d by						1 □ Ye	s 2 No 3 F	Probably 4 Unknown	
Ö	w requir s been s should	Completed						24a. Was ar		utopsy findings available	
Re	The law ite has age 2:	шо		.,				autops perforn 1 □ Yes 2	ned? death?	completion of cause of s 2 □ No	
ital	sician: The certificate h rector, page	BeC	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only one		22	
∑ V	hysic this ce	ျ	1 ☐ Yes 2 No	lospital:			4 LI Nuising no		nce 6 Dother (Sp	ecity) Assurd Living	
_	ding Ph h. After th funeral	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time o	Wor	ryat k? lYes 2 □No	28d. Describe ho	w injury occurred	ŀ	
Division	Attendation death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	/ At home, farm, str		7103 2 2 110		reet and Number or F	Rural Route Number,	
D.	al or / s after il Dire	Serti	4 ☐ Homicide determined	building, etc.	(Specify)			City or Town	, State)		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		(Check only 2 Medical Exam	sician: To the best of iner: On the basis of	xamination and/or in	th occurred at the ti	ime, date and place opinion, death occur	, and due to the carred at the time, d	ause(s) and manner ate and place, and du	as stated. le to the cause(s)	
	thin 2 the I	Medical	one) 29b. Signature and title of certifier	and manner state	ed.	29c. Licens	se number	2	9d. Date signed (Mor	oth, Day, Year)	
	F.≚ F 8		Allalin	2				1			
	\sim		30. Name and address of person who c	ompleted cause of dea	ith (Item 23a) (Type,	Print)	() () -	<i>'</i>	MPRK 24 MD 21.		
	10		AARON J. CHAS.	ues my	67011	N. Chan	us st 7	owson .	21.	204	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	D 00.					

DHMH 17 Rev 1/2001

		1 State		partment of Health and Mertificate of Death								
1 A 1 A	Ř	1. Decedent's Name (First, Middle, Last)		erillicate of Death	Reg. 2. Date of Death	3. Time of Death						
Physicia /Medic		Lillian Bertha	Booke		04/21/							
Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 5651 Sargent Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	4b. City, Town, or Location of Death Hyattsville // If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Prince Georges 9. Birthplace (State or Foreign						
Director			84 Yrs.	Months Days Hours Min.	(Month, Day, Ye. 09/06/19	ar) Country)						
Maryland a-f show	tor	MD 10b. County Prince Georges	10c. City, Town or L	Occation Hyattsville		10d. Inside City Limits 1 ☐ X es 2 ☐ No						
th with the 23a or 28a ist be not	al Director	10e. Street and Number 5651 Sargent Road		10f. Zip Code 20782	10g.	Citizen of What Country?						
15-0036 n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notifled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent E. Armed Forces? 1 □ Yes ☑ Widelight Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black						
21215-003 d within 72 hours a griene. er than "natural"; the Medical Exar	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Giv	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired) DUSE Keeper	ng	Rind of Business/Industry						
	Be	17. Father's Name (<i>First, Middle, Last</i>) IVey Vest	110		(First, Middle, Maid Jackso	den Surname)						
ary	To.	19a. Informant's Name/Relationship (Type. Print) Shirley M. Boone/Daughten			al Route Number, Ci	ty or Town, State, Zip Code) 20743						
other		20a. Method of Disposition 1 Burial ZCremation 3 Removal from State	28/08 20c	Location - City or Town, State								
Baltimo permit. Page Department of Important: If any injury or once,		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			ald Tayl	verdale, Maryland or II Funeral Hm.						
7		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition assulting in death) a. CORONARY ARTERY DISEASE										
Physician /Medical Examiner		disease or condition resulting in death)	consequence of):	LE BRANCH B		5						
uted d	Examiner		consequence of):	ENSION								
58 / 50, ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	concomionos of).	TIVEHEARTH	AIWR	6						
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cords, P.O. w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
	Completed				24a. Was an autopsy pertormed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No						
Vital sician: T certificat rector, ps	Be	25. Was case referred to medical examiner? Hospital: Hospital:		26. Place of Death								
on or ding Phys	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day)	t 2 ☐ ER/Outpatie 28b. Time Year) Injury	of 28c. Injury at	me 5 N Residence 28d. Describe how in	e 6 Other (Specify) njury occurred						
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 □ Addident	y - At home, farm, s (Specity)		28f. Location (Street City or Town, St	and Number or Rural Route Number, late)						
he Hospita n 24 hours he Funera pletely fille	Medical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of and manner state	examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)						
To ti withi To ti comi	Ž	29b. Signature and title of certifier Once Am a	2 M.D	29c. License number D 36/9 2	29d. A <i>P.</i>	Date signed (Month, Day, Year) RIL 25, 2008						
3		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type 610 CAR	ROLL AVE. SUITE	410, 7	AKOMAPARK, MDZOGYZ						
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	Cooli		7						
DHMH 17 Rev 1/20	001	ALL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** рм Richard A. Burkett 04/24/2008 **6:**30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 6 Skylark Court 1B Maryland Parkville If Under 1 B. Date of Birth (Month, Day, Year) 08/17/1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Months Davs MM 2□F Baltimore, Director 212-30-0526 73 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No by Funeral Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Skylark Court 1B 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

Yay Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printer Wholesale Packaging 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Frederick Burkett Ada Agnes Daugherty 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly J. Cantrell (Daughter) 4015 Highland Avenue, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 04/29/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Marca 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ing physician and e as the burial-transit that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐ Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Tes 20 No 5 Residence 6 □Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natura! 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rom Woods 31. Date filed (Month, Day, Year) 32. State APR 29 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month nreu 4a. Facility Name (If not institution, give street and number) lown, or Location of Death 4c. County of Death Baltimore Augsburg Lutheran Home Gwynn Oak 8. Date of Birth NOV 22 1921 5. Social Security Number Sex 14 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs._ 9. Birthplace (State or Foreign Months Days Hours Min. Maryland 218-14-8705 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 6825 Campfield Road Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Connelly Jeannette Strohmeyer Arthur Boslev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Winifred Connelly - wife 6825 Campfield Road, Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/28/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Throm bosis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 INO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □ Yes

26. Place of Death (Check only one,

Physician /Medical Examiner

item 2

Department of Important: If it any Injury or conce.

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25. Was case referred to medical examiner?

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-tran P.O. Box 68760, the Division of Vital Records, page 2

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within 2 To the comple	Ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year April 27, 2) 24
6+1		30. Name and address of person who	o completed cause of death (Item 23a) (Type, Print) ROB MIN 25 MAIN SPEC 2//3	36
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State of Maryland / Department of Health and Mental Hygiene 2008 13816 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 21, 2008 1135 hrs al Examiner Leo Century, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore N/ASaint Agnes Hospital 9. Birthplace (State or Foreign S. Carolina 7. Age (In yrs. last birthday) 54If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year 5. Social Security Number **Funeral** 247-15-0031 Months Hours July 2,1953 Director Country) 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Baltimore 1X Yes 2 No N/AMaryland 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other trainmatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 1709 Ashburton Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Specify: Black 1 Yes 2 X No specify: 3 X Widowed 4 Divorced If Yes, Give Year 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Chesspeake Roofing Elementary/Secondary (0-12) College (1-4 or 5+) Roofer 12th grade Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Lee Canty Leo Century, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 2826 Windsor Avenue Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Bogan Century, Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Mt.Zion Cemetery 1 X Burial 2 Cremation 3 Removal from State Lansdowne, Maryland 4/28/08 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Livensee Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 1. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ohysician Between Onset and failure. List only one cause on each line. Medical Death Hypertenive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminerء or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED X #M,25EP,27,perME,g879 5/30/08 TI attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó ò 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has certificate has rector, page 2 s death? performed Yes 2 V No 2 No 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other 7 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 V Yes After the 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 22, 2008 O.C.M.E. 1 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) APR 2 9 2 Registrar's Signature OCME Registra

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Day MARY ANN CHARLTON APRIL 26, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOLDEN LIVING CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 65 Director 305-46-5162 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any july or other traumatic event, the Medical Examples. 10a. State 10c. City, Town or Location 10b. County Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 21157 1266 OLD MANCHESTER RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LIBRARIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OBIE CHARLTON MABLE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RALPH CHARLTON -BROTHER P.O. BOX 23347, COLUMBUS, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3X Removal from State OAKTOWN CEMETERY 5/5/08 4 ☐ Donation 5 Other (Specify) 21. Signatur of Egheral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** tho Sarci disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Jas autopsy performed certificate 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of After t 28c. Injury at Work? Certification: 1 Natural 5 Pending Injury investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

 Birthplace (State or Foreign Country) 12/12/1942 INDIANA 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry EDUCATION ATWELL OHIO 43223 20c. Location - City or Town, State OAKTOWN, INDIANA Approximate Interval Between Onset and Death 3mm 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. munchester.

11:35P

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name of d address of person who

31. Date filed (Month, Day,

John W. Middlefor

Year

within 24

completed cause of death (Item 23a) (Type, Print)

333

29c. License number

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Marie Coker 12:54 A M 2008 April 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Columbia Howard 8. Date of Birth (Month, Day, Year)
Nov. 25,1903 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👽 F Months Days Hours Min 579-22-7416 104 Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Mudical Expiritue Invest be retitled at once. Funeral Director 1 ☐Yes 2X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane #275 21044 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □XNo þ Specify: Specify: 3 √2 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Lickey Mary Eleanor Slack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Binckley 5403 Lighthouse Court Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other p 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 4 Donation 5 Other (Specify) Cemetéry 22. Name and Address of Facility
Witzke Funeral Homes,
5555 Twin Knolls Pood, 5-20-2008 Arlington, VA 21. Signature of Funeral Service Licensee MO1050 Inc. Columbia, MD 21045 1 Y 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nouv /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy perfor m certificate 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 1 Yes 2 No this (1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records, I hours after death.

uneral Director: A

ely filled in by the fu death. To the Hospital within 24 hours a To the Funeral C completely filled

Box 68760,

Baltimore, Maryland 21215-0036

State

Registrar DHMH 17 Rev 1/2001

Medical

82

29b. Signature and title of certifie

4 Homicide

29a. Certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 9 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2ďď8 7:10 pm Dudley Valrie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Balto Stella Maris Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-24-1956 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 51 MD Director 220-64-7654 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event it is the Marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event it. Director XXYes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 5715 Newholme Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐Yes 2 If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐Yes 2 XNo Specify \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation State of MD Dept 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Corrections 12th grade years Correctional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Curtis Lamarr Dudley ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5715 Newholme Avenue Balto, MD 21206 Janaki Martin-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4-25-2008 Balto, MD Greenmount Cem 4 ☐ Donation 5 ☐ Other (Specify) March F/H East 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. North Avenue MD 21202 Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 K No Day Year 5 Other (specify) P.O. ed by the detached 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Vital 2X No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) **HOSPICE** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ō this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division Hospital or Attending 1 X Natural s after dec. 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in ! 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

2008

VALRIE DUDLEY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIO MAHMOOD

APR 29

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien@ [] [] []

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2 Day 2008 BARTON DUGDALE 8:00 A M april /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner None Roland Park Place Baltimore if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Months Days Hours Min. (Month, Day Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M XXF Illinoïs 109-14-1340 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items be notified at sumatic event, the Medical Examinar must be notified at 1 XXYes 2 □ No Director Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 USA 830 West 40th Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXXNo White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, is 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Barton Violet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Grace Ridge Court Monkton Maryland 21111 William Morris Dugdale Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 □ Cremation 3 □ Removal from State St Pauls Epis Churh Cemetery Apr 30,2008 Donation 5 ☐ Other (Specify) Chestertown, Maryland ignature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc (enals 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the dis ...e, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Deau Immediate Cause (Final disease or condition resulting in death) musewideal infarction **Physician** /Medical Due to (or as a consequence of): Examiner Years aritery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by caspruetine 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1□ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Certification: To Be 26. Place Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Gregor MD M Isabelle Mac 013657 april 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

APR 2 9 2008

D. IPABELLE MACREGOR, 830 W 40 Th STREET, BALTI OTORE, OT & 21211 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month nna /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis more town Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours 1 ☐ M 2 ☐ XF 80 Director Yrs. 220-24-1643 Nov.17 1927 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, it is Modical Executed Trust be notified at 1⊋Yes 2□No Maryland N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2911 Fendall Road 21207 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ges 1 and 2 should be filed within 72 hours after t of Health and Mental Hygiene. If item 27 Is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: þ Specify: Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private family 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Barnes Florence Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernell Roberts/ 2911 Fendall Road Baltimore, Maryland 21207 Niece permit. Pages 1
Department of He
Important: If iten
any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mt. 4/25/08 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md21215 21. Signature of Funeral Service License Ceruso 23a. Part1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final, End Pnysician age disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day 4☐Pregnant at time of death 5 Other (specify) the detached δ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 D No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2□ No 1 🗌 Yes 2 🗆 1 🗆 Yes To the Hospitel or Attending Physicien: after death.

Director: After this certific
I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 70 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 DMatural 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature

State Registrar

DHMH 17 Rev 1/2001

gistrar's Signatu

APR 2 9 2008

Randallstown, MD 21133

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ap^{Month}1 27° 2008 10:36am Julian Bernard de Leyer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | N 0 V . 20 3 1949 9. Birthplace (State or Foreign 9. England 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 58 219-84-5217 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2√☐ No Baltimore Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United Kingdon SA 21234 2506 Ebony Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analyst Legg Mason 18. Mother's Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Julian Alphonse de Lever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2506 Ebony Rd. Baltimore, Md. 21234 Beverly de Leyer/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Co.4-29-08 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/License ²² Ruck Towson Facility Funeral Home, 1050 York Rd. Towson, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) to resal 8 moderance ans runtus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autonsy perform 1 □Yes 2 WNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WoSpile Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Division of Vital Records, P.O. Box 68760,

burial-trar attending physician for use as the burial ned by the a Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate hately filled in by the funeral director, page within 24 hours a To the Funeral D

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permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
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Physician

filed within 72 hours after death with

altimore, Maryland 21215-0036

/Medical

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

CHAMES M 32. Registrar's Signature

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

701

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

29d. Date signed (Month, Day, Year)
ANNIL 27 2008

Charles St tonson us 21204

State of Maryland / Department of Health and Mental Hygiene Cartificate of Death

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Medical Certification: To Be Completed by Physician/Medical Examiner

For State Registrar		State of Ma	aryland /		artment r <i>tificate</i>				lental Hy	/gien Reg. N	211	08	13	821
1. Decedent's Name	e (First, Middle, L	ast)							2. Date of D	eath		Voor		of Death
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4a. Facility Name (/ Saint	f not institution, g	ive street and number) n Medical	Cent	217	4b. City, 1	own, or		of Death	on	4	c. Coun	ty of Deat Bal	h timor	° @
5. Social Security N 213-28-4 Usual Residence of	958	Sex 7. Ag 1□M 2XIF	e (In yrs. last	yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.						irth lay, Yea 5 , 1	^{r)} 931	Co.	hplace (Statuntry) rylanc	e or Foreign
10a. State	10b. County		10c. City, To	wn or Lo	cation								10d. Inside	City Limits
Maryland	Baltim	ore	(locke	ysvil	1e							1 □ Y	es 2XNo
10e. Street and Nu		010		Joene	10f. Zip					10g. C	Citizen of	f What Co	untry?	
17 D Nu	tmeg Kno	11 Court				210	030				Ţ	JSA		
11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Deced	ent of H	ispanic O	rigin? (Sp	ecify Yes or N Rican, etc.)	0-		ace - Ame	rican Indian,	
1 X Never Marr 3	ied 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 🕅 f If Yes, Give Year or Dates:	10		1 ☐ Yes 2		Specify		, , , , , , , ,			ify:Whi		
(Spec	15. Decedent's l	Education rade completed)	16	Sa. Decec	tent's Usual kind of work DO NOT use	Occup	ation during mo	st of work	ing	16b.		Business/l		
Elementary/Seco	ondary (0-12)	College (1-4or 5							ntant		Aore	2022	0	
12 17. Father's Name	(First. Middle, Las	04		erti	TTEU	Pub.			e (First, Middle	e. Maide		ospac	е	
Walter	C1a)oyle					da	o (1 1101) 11114411	Haz	_	· _	eBrun	
19a. Informant's Na				9b. Mailin	ng Address	(Street a			al Route Num					
	· .	Personal Re							d, Bal				21211	
20a. Method of Disp	position		20b. Place	of Dispo	sition (Nam	e of			Date	т -			Town, State	
4 □ Donation	Cremation 3 Street Special Street	Removal from State		Cre	emator	у	1	4/28	3/08	Ca	aton	svill	e, Ma	ryland
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23a, Part1, Enter t	he disease, or col	mplications that c tused y one cause on e ch lir	the death. D	o not ente	er the mode	of dyin	g, such a	s cardiac	or respiratory	arrest,	, 110	11,10	Approxim	nate
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resulting in death)	4	Due to (or as		e of):										
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Sequentially list co if any, leading to in cause. Enter Unde	nmediate erlying	Due to (or as	a consequenc	e of):										
that initiated events resulting in death) I	frijurÿ 💮 🚡	с												
resulting in death) i	Lasi	Due to (or as	a consequenc	e of):										
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23b. Was deceden in the past 12 1 ☐ Yes 2 ☐	months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal dea		Ectopic pre Other (spe					(3)		ate of deli Ionth	very Day	Year
9 ☐ Unknown		9□Unknown								j				
Part II. Other signif	ficant conditions	contributing to death be	ıt not resulting	in the ur	nderlying ca	use give	en in Part	L.	23e. Did			ntribute to	the cause of	of death?
		 							1 🗆	Yes	2X No	3 ☐ Pr	obably 4 [Unknown
									24a. Wa		24b	. Were au	topsy finding	s available
										opsy formed? 2 24. 0		death?	2 X No	cause or
25. Was case refer examiner?	red to medical						26. Plac	e of Deat	h (Check only		10			
1 □ Yes 254	No	Hospital: 1 X Inpatie	nt 2□ER/0	Outpatien	t 3□ DO/	Othe	er: 4□N	lursing Ho	me 5□Res	sidence	6 □0	ther (Spec	cify)	
27. Manner of Deat 1 Natural	h 5	28a. Date of Inju (Month, Day		Time of Injury	28	Bc. Injun Worl	at		28d. Describe	how inj	jury occu	urred		
2 ☐ Accident 3 ☐ Suicide	investigation	ho I			М		Yes 2]No						
4 ☐ Homicide	determine		ry - At home, :. (Specify)	farm, stre	eet, factory,	office			28f. Location City or To			nber or Ru	ral Route N	umber,
29a. Certifier	1 Certifying F	Physician: To the best	of my knowled	lge, death	occurred a	at the tin	ne, date a	and place.	and due to the	e cause	(s) and r	nanner as	stated.	
(Check only one)	2 Medical Exa	aminer: On the basis of and manner sta	examination	and/or inv	vestigation,	in m y o	pinion, de	eath occur	red at the time	e, date a	ind place	e, and due	to the caus	e(s)
29b. Signature and	title of certifier				29c.	License	number			29d. D	ate sign	ed (Month	n, Day, Year)
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30. Name and addr	ress of person who	o completed cause of de	eath (Item 23a	a) (Type, I	Print)						-			
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State Registrar

1-	For State Registrar	
1. D	ecedent's Name (First, Middle, Last)	

State of Maryland / Department of Health and Mental Hygiene 0000 Certificate of Death

Physician
/Medical
Examiner

2. Date of Death Month

3. Time of Death

	/Medic	cal		l	Muriel J	uanit	a De	Vilbiss		April	26	, 2008	5:40	A M	
San San San San San San San San San San	Examin		4a. Facility Name (If not	institution, giv	e street and number,)		4b. City, Town,	or Location of			. County of Death			
, ar			GOLDEN L		CENTER				INSTE		CARROLL				
	Funeral		5. Social Security Numb			ge (In yrs. la	ast birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of B Min. (Month, D	irth av. Year	9. Birth	nplace (State or I	Foreign	
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			shock, or heart fai	lure. List only	one cause in each li	ne_				ial '		.)	Approximate Interval Betwee Onset and De	een	
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00,	e exe ian a irial-		resulting in death) Last		Due to (or as	a conseque	ence of):								
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٥.	deat e att	icia	in the past 12 mon 1 ☐ Yes 2 🛣 No	ths?	4 Pregnant a	t time of de		Ectopic pregnand Other (specify) _	cy 			Month	Day Ye	ar	
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	that ned I	y P	Part II. Other significan	t conditions	ontributing to death b	ut not resul	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of dea	ath?	
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	ing F After Jinera	Certification:	27. Manner of Death	Pending	28a. Date of Inju (Month, Da	ıry 2 y, Year) 2	28b. Time of Injury	28c. Inju Wor	ry at rk?	28d. Describe	how inju	ry occurred			
2	end eath. or: /	cati	2 Accident	investigation				M 1 🗆]Yes 2 □ No						
>	r Att	ij	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place of Injusting, et	ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location City or To	Street at	nd Number or Rur e)	al Route Numbe	э <i>г</i> ,	
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	1		30. Name and address of	of person who	completed cause of d	eath (Item :	23a) (Type. I	Print)		1		1-1-0			
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		T - State of Mary State of Mary Registrar		artment of He rtificate of D			giene 2	008	13826						
		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death						
Physic		Elmer Joseph Dunne				April	27. 200	Year 18	12:00 pm						
/Medi Exami		4a. Facility Name (If not institution, give street and number)	-	4b. City, Town, or I	Location of Death	110111	4c. County		12:00 [2.1						
-Autim		Lighthouse Senior Living		Essex			Balt	imore							
Funeral		5. Social Security Number 6. Sex 7. Age (/	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day		9. Birthpla	ace (State or Foreign						
Director		213-01-5495 ¹₽XM 2□F 9	94 Yrs.	Months Days	Hours Min.	4/19/19	14	Count Mary							
P .		Usual Residence of Decedent			<u> </u>			140							
arylar show	-	10a. State 10b. County 10	0c. City, Town or Lo	ocation				10	d. Inside City Limits 1 Yes 2 No						
Ba-f	Director		Baltimore												
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ath w	Funeral	1917 Hillenwood Road		21239			U.S.A								
tems	nue	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Blad	ce - America ck, White, et							
s affe	by F	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 ፫፮ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 🕱 No	Specify:		Specify	y:							
be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm Medical Evertine must be notified at	b h		16a Dooo	dent's Usual Occupa	tion		16b. Kind of B	Whi							
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VICE YICH CLE 12 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, Inc.	2	Elmer F. Dunne 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a			er. Citv or Town.	. State. Zip	Code)						
INICA Id 2 s Iffh an 27 is 1 trau		Joseph Dennis Dunne (Son)		•	Roaedal			•	,						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Wedleal Eventines must be notified at once.	- 0			osition (Name of matory or other place		Date	20c. Location		vn, State						
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permit. Departr Importa any Inju		Marchael C Sallar	B	ruzdzinski 407 Old Ea	Funeral	Home P.	A ssex. M	arvla	nd 21221						
		23a. Part 1. Enter the disease, or complications that caused the							Approximate Interval Between						
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leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of purchases the past 12 months?		Ectopic pregnancy				te of deliver							
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r Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (3	- At home, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numb	per or Rural	Route Number,						
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only) 1 Certifying Physician: To the best of m	ny knowledge, death	h occurred at the tim	e, date and place, inion, death occur	and due to the o	cause(s) and m	anner as sta	ated. the cause(s)						
the H nin 24 the F	ledi	one) and manner stated													
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J.U. Sta Registr		30. Name and address of person who completed cause of death 9110 Philocole Inhier Rd 1. 31. Date filed (Month, Day, Year) 32. Begistrar's	3a Ho, Y	ND 212	-37										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death ecedent's Name (First, Middle, Last) Date of Death **Physician** 26, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center + Kehab Hmore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Min Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 tvenue by Funeral ennose 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use tetired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) econdary (0-12) College (1-4or 5+) 8th Collector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be terquison ouise ပ 19a. Informant's Name/Relation 19b. Mailing Address (Street and Number or Rural Route Number hip (Type. City or Town, State, Zip Code, lord 20a. Method of Disposition Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral 99r vice Licens Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE IEW DAYS **Physician** ACUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical e attending phy d for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify). 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEMATURIA SEIZURE. Capp 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has le 2 s autopsy performed. 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of penitier 0 29c. License number 29d. Date signed (Month, Day, Year) 1) 6062634 MA 28/20:8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATERN MA COLUMBIA 108-2 HICKORY RIDGE AS 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 A State of the said Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

1-	For State Registrar
_	negistrar

1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death Month

3. Time of Death

Physician
/Medica
Examine

Physici		CINDY B.									Month APRIL	Day	200	Year	2:37 p ^M
/Medio Examir		4a. Facility Name (If not institu			umber)			4b. City, Town	or Location	of Death	111 1(11		County of		
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aryland show		10a. State 10b. Cour	MY ATT	mde1		10c. City, To Seve	own or Lo	cation						100	I. Inside City Limits
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death certificate be executed eathending physician and dor use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, or	utcome of	pregnancy						2	3d. Date	of delivery	
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Registrar

APR 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Physician 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA MARYLAND UNIVERSIT 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Year Months -26-58 1 □ M 2**X** F 1922 SOUTH CAROLINA Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1XYes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 'natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No Baltimore, Maryland 21215-0036 BLACK ò 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within College (1-4or 5+) is marked other than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than HOME GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MARVLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Libensee FULTON P n1. En er he disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory frest, shock, or beart failure. List only one cause on each line. In ediate Cause (Final Isease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 1EMORRHAGE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant ned by the atten e detached for u 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9541 Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has 1 Yes within 24 hours after usus...

To the Funeral Director: After this certification and the funeral director, is a manietely filled in by the funeral director, is Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and ti e of certifier

3

DHMH 17 Rev 1/2001

State Registrar

SOUTH GREENE ST., BALTIMORE, MD 2 120 1 32. gistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 28 2ŎŐ8 Suanne Marie Felix 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 8983 Furrow Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25, 1956 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🔀 F 399-48-7319 51 Wisconsin Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 8983 Furrow Avenue 21042 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 □ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Therapist Health Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ristow Beulah Marie Kohl ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Felix (Husband) 8983 Furrow Avenue Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Pk. 4-25-2008 Clarksville, MD ^{22. Name and Address of Facility}
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 0 **Physician** months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year 5 Other (specify) ☐Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) 30. Name and address of person who complete 3+1 Edward J. Lee, MD 11065 Little Patuxent Parkway Columbia, MD 21044 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. \angle 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year В 9:52 AM arnell 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gui Iford Baltimore
Inder 1 Year | If Under 24 Hrs. Security Number 8. Date of Birth Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-66-5558 1 □ W 2 □ F Months Hours Min Director 11.19 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Tes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 1925 Guilford tvenue 31218 12. Was Decedent Ever in U.S. Armed Forces? 1U⊒Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Spence

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type. Print) Brown Guilford Ave Baltimore, MD
Date 20c. Location - City of ecilia altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest 22. Name and Address of Facility Vaugna C. Greene Fineral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician asthma Acute exacerbation /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinitely accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Obstructive 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has funeral director, page 2 s autopsy performe certificate ! 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ■Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide hours after within 24 hours a To the Funeral L 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

North Greene Street

BUAMC

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Marshall

2008

31. Date filed (Month, Day, Year)

APR 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Gatling 12:584 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 36/9 Coronado Koad Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. B. Date of Birth (Month, Day, Year) D7 04 1940 Birthplace (State or Foreign Country) **Funeral** Months 216.36.056 1**XX**M 2□F 67 Yrs MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at Baltimore Baltimone 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Iral", or items 23a or Examiner must be Coronado Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Mechanic 3 years 12th grade Pages 1 and 2 should be filed valent of Health and Mental Hygic ant: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archer Gatling Gertrude Gatlina ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Road Baltimore MD 21244 loria D. Gatling 3619 Coronado Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 04/28/08 Baltimore MD butus Memorial 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn (. Greene Funeral SNCS auxh 8728 Liberty Road Randay Stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Metastatic Colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 222216 4/25/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 23 Crossopeds Dr Owings Wills, md. 2/117 4.0 32: Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Shirley Jean Garris 08 0929M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 94 ned 0 unune 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 63 Months Days Hours Min 1 M XXF Director 219-40-7724 9-17-1944 N.C. Usual Residence of Decedent 10a, State 10c. City, Town or Location show 10b. County 10d. Inside City Limits at notified Director Anne Arundel Pasedena 1 ☐Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō g Funeral items 23a 8341 Catherine Avenue death the Medical Examiner must 21122 SA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 27 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**7** No 9 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce. College (1-4or 5+) Senior Citizens 12th grade Nurses Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental John Willis Bowser ပ Mary Eliza Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaheyla Garris-Daughter 2710 Robson Court Richmond, VA 23233 timore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State T∑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-30-2008 Anne Arundel Co, MI Cedar Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1 North Avenue Balto, 1101 Ε. MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5045 /Medical as *consequence of) **Examiner** betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: esn. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9□Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforr certificate 1∐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 1 Innatient 2 ER/Outpatient this funeral 27. Manner of Death 28a. Date of Injury After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident (Month, Day Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.O. Box 68760. Division or Vital Records, 24 hours after death Hospital completely within 24

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

25

32. Registrar's Signature

ON

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #8 Per FH G879 5/01/08 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>008</u> **Physician** FRANCES YEAGER GIBBS 1:13P 27, April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death **Examiner** Stella MAris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Appropria, Day, Year) Sept. 28, 1917 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** Hours Months Days 1 □ M Yrs. Director 213-01-0140 90 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Yes 2 No Director Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 B Hamill Road 21210 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2**X**No þ Specify Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Balto City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Yeager Sr Crescentia Huber ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lee Gibbs 1210 Doves Cove Road Towson, Maryland 21286 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 □ Burial 2 XX remation 3 □ Removal from State GreenMount Crematory | Apr. 29,2008 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Se 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseas, or complic 1/2 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on-cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 **K** No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes 2 🕱 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🕱 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c_License number 29d Date signed (Month, Day, Year)

5

2008

27,

FRANCES

State Registrar 31. Date filed (Month, Day, Year)

DR. ERNESTINE WRIGHT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fh e8/8 4-28-08 vt
State of Maryland / Department of Health and Mental Hygiene

1 - State amend item 11 per granddaughter 881 7-17-08 vt

Reg. No. 2 0 0 8 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL Year 12:30PN WILLIAM MCKINNEY GILLIAM 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY 11 W. 20TH STREET, APT. 20 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7–15–1927 9. Birthplace (State or Foreign Sex XXX м 2□ F **Funeral** Months Days Min. Hours NORTH CAROLINA 246-30-6278 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show MD BALTIMORE CITY Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 11 W. 20TH STREET, APT. 20 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No ARMY If Yes, Give Year or Dates: 1950–52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify BLACK þ Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Mental Hygiene. narked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) VETERANS ADMINISTRATION LABORER is marked other 18. Mother's Name (First Middle, Maiden Surname)
GOLDEN S. ASKEW 17. Father's Name (First, Middle, Last) Be JOHN H. GILLIAM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau once. 4627 CHATFORD AVENUE, BALTIMORE, MD 21206 VIRGINIA GILLIAM / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY 4/28/08 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Let the clease, or complications that caused the de r heart vilure. List only one cause on each line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, Cause (Final **Physician** diseas or condition resulting in death) ours /Medical Examiner Sequentially liet en difform, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical MA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed thme 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely

State Registrar 29b. Signature and title of certifier

eman n.s

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

29c. License number

avene Shiel

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. G879 5/06/08 Pentiment of Health and Mental Hygiene G879 5/06/08 Certificate of Death 1 - For State Registrar amend #1 Per Phy Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John В. Gibson, SR. Day Month Year **Physician** 614 JOKA 504 13:59 Apr. 2008 /Medical Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 215-26-9080 Yrs. **Director** 76 6-8-1931 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 XYes 2 □ No MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21213 USA Funeral 1938 E. Lafayette Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify: Specify: Black ş 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Unk life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Master 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gibson Uvilla Wilson George H. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John^BGibson, Jr -Son 500 Epsom Road Towson, MD 21286 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cem 4-29-2008 Balto, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H East 23a. Part 1. Enr. The disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Balto, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition نسوءلا /Medical resulting in death) Due to (or as a consequence of): Examiner circhosi Liver Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 1 ☐ Yes 2 XNo Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA ည After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No eral Director: A filled in by the f 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 April 22, 2008 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 29

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 ten 18 per fh 88/8 4-29-08 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Joseph Green 22, 2008 Apr. 1:12P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Joseph Richey Hospice Baltimore Months Days Hours Min. Oct. 8, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F S.Carolina 251-24-8887 Director 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland N/A Baltimore Director Apt. 215Bof. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ronce. 2121 Windsor Garden Lane 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Black 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
FORK LIFT Operator 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Canton Railroad Elementary/Secondary (0-12) College (1-4or 5+) 5th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah Green 19a. Informant's Name/Relationship (Type. Print)

Jodell Bush/ Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1901 Elgin Avenue Baltimore, Maryland 21217
Apt. 302 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/08 Lansdowne, Maryland Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Chatman-Harris Funeral Home 21. Signature of Funeral Service Vienses 22. Name and Address of Facility 5240 Reisterstown Road Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG Physician CINCER to Lerdolun Dauentis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death signed by the at d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No s certificate has b lirector, page 2 sl 24a Was an useph Greene 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check onl one Other: 4 Nursing Home 5 Residence 6 Mother (Specify, Hospital: 1080168 20 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of dertifier DOG 030 - Mary 124 April 22, 2005 29d. Date signed (Month, Day, Year) My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. B. Hi way MD 21210-1303 9 W. Laker L- KWOX Wevi d 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 29 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23 2008 April 12:25a M Marilyn V. Gilson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Howard Columbia 9358 Reader Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Nov. 26, 1943 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours Months New York 64 104-34-2404 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ∏Yes 217 No Columbia Maryland Howard 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 U.S.A. 9358 Reader Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ∐Yes 2 TXNo Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County Public College (1-4or 5+) Elementary/Secondary (0-12) School System Reading Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris R. Rice Gordon L. Bishop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 East Erie Street Unit#203 Milwaukee, WI 53202 Ginny Gausden (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Pk. 4-28-2008 Clarksville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23 Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road Co MO1050 γ Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final METasTATIL Phyllones Tumos of the breast to the disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

item 27 i

permit. Pages 1 Department of H Important: If ite any Injury or ot

within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Examiner Physician/Medical ò Completed

burial-transi and attending physician for use as the burial page 2 should Be

signed by the a d be detached for peen

certificate be executed After this certificate filled in by the funeral director, Hospital or Attending P
 24 hours after death.
 Funeral Director: After t To the Hospital of within 24 hours a To the Funeral D

Certification: To Medical

State Registrar

25. Was case referred to medical examiner? 1☐Yes 2☑No

27. Manner of Death 1 Natural 5 Pending investigation 2 ☐ Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

6 ☐ Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number D38509

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholus Kontrelakes 11065 Little Paraxent Pty Columbia, Mary Jamis 21044

32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM Floe, per FH, 0878, 4/29 08 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Harnngton elen 44 AM APRIL 01 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SAINT AGNES N/A HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Country) 213.32.3883 1 ☐ M 2 🗹 F NC Director TI 01/11 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show Baltimore MD 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 709 Charing Cross Road 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Back 1 ☐ Yes 2 🗖 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th grade Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sturdivant Emma Louise Broadaway Charles ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4308 Wynfield Drive Owings Mills MD 21117 narmaine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20 Location - City or Town, State 20a. Method of Disposition Date 1 ⊠ Burial 2 ☐ Cremation 3 Removal from State Battimore MD 05/02/08 Memorial 4 ☐ Donation 5 ☐ Other (Specify) Arbutus 22. Name and Address of Facility Vaus M C. Greene Funeral Services 21. Signature of Funeral Service License any ir 8728 Liberty Road Randallstown MD 21133 au 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Possible acute myo cardial interction **Physician** /Medical Due to (or as a consequence of): Examiner 5 weeks carcinoma Lung 5 quanticity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the Ö law requires that the 9 Unknown been signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HARRINGTON Division or Vital Records, <u></u> encephalopathi 1 Yes 2 No 3 Probably 4 Unknown Completed coaquiatio disseminated 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No intravascular has autopsy performed? The within 24 hours after death.

To the Funeral Director: After this certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 24, 2008 D0056143 MD 12hu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIRAYMOND ZHU, DEPT. PATHOLOGY, 900 CATON AVE, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	Otate of Marylan		ertificat			entai 11	Reg. N	2000	3841		
	Physici	an	1. Decedent's Name (First, Middle, La	•					2. Date of D		ay Year	3. Time of Death		
	/Medi			. Hollands					April	25,	2008	11:05 P.M		
	Examir	ier	4a. Facility Name (If not institution, gin Stella Maris	ve street and number)			Town, or Loca imoniun			4	c. County of Death Balti			
	Funeral Director		170-07-3892	Sex 1 □ M 2√ F 7. Age (In yrs. 9		Months		nder 24 Hrs. urs Min.	8. Date of B (Month, L	Birth Day, Yea 23/1	r) 9. Birth Cor 1912 Penr	nplace (State or Foreign intry) ISYlvania		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town o	r Location						10d. Inside City Limits		
	e Maryla la-f sho tified at	ctor	Maryland Balti			Sparks						1 ∐ Yes 2 x∑k No		
	ath with the 23a or 28	ral Director	10e. Street and Number 2 William				152				citizen of What Cou nited Sta of Ameri	_ca		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If meath and Mental Hygiene. If is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.s.	13. Was Deced If Yes, spec 1 ☐ Yes		c Origin? (Spe xican, Puerto ecify:	ecify Yes or N Rican, etc.)	No-	14. Race - Amer Black, White Specify: W			
5-0	n 72 h "natu edical	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	ecedent's Usua Give kind of wo fe. DO NOT us	al Occupation rk done during	most of worki	ng	16b.	Kind of Business/I	ndustry		
2121	d within giene. rr than the Me	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	"	accou					fir	nance		
P.M. Maryland 21215-0036	i 2 should be filed w h and Mental Hygiei i s marked other th raumatic event, th	To Be C	17. Father's Name (<i>First, Middle, L</i> as Edwin Brunn	•			18. M	Nother's Name Elle	(First, Middlen Tros		en Surname)			
P.M.	and 2 shows alth and N 27 is maer trauma	1	19a. Informant's Name/Relationship Barbara Cernik/	daughter	2	2 Willi	am Cour				or Town, State, Z yland 211			
11:05 altimore,	permit. Pages 1 and 2.s Department of Health an Important: If Item 27 is any Injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 [4 ☐ Donation 5 ☐ Other (Special Content of the conten	Removal from State 20b. F	Place of D cemetery, ans f apel-	isposition (Nan crematory or o Suneral Bel A	ne of therplace) ir	April 2008			Location - City or T Forest Hi	Гоwn, State 11, Marylaı		
1 Balt	permit. Departi importi any inj		21. Signature of Funeral Service Lice	ensee /	- 1	22. Name an	d Address of F	acility				on Ctr.,P.A and 21093		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death y one cause on each line.	h. Do not	enter the mod	e of dying, suc	h as cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Deat Onset and Deat											
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	ped List	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):										
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25, 2 0. Box	law requires that the death cer as been signed by the attendin 2 should be detached for use	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	l death	3 □Ectopic pr 5 □ Other (sp					23d. Date of deli Month	very Day Year		
'nΦ.	s that t ned by e detac	by Ph	Part II. Other significant conditions	contributing to death but not resi	ulting in th	e underlying c	ause given in I	Part I.	23e, Dio	tobacco	use contribute to	the cause of death?		
APF ords	w requires that been signed to should be deta	led b	Parsufis						1	Yes	2 ⊠ No 3 □ Pro	obably 4 Unknown		
OLLANDS APRI or Vital Records,	The ate h	Completed	1/2/11/2						24a. Wa aut per 1∐ Yes	topsy rformed?	prior to c	topsy findings available completion of cause of		
.A.N.	cian: sertific setor,	Be (25. Was case referred to medical examiner?					Place of Death						
H	Q 18.	2	1 Yes 2 No 27. Manner of Death Vatural 5 Pending investigation investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpa 28b. Tim Inju		Other: 4[8c. Injury at Work? 1 Yes	2			6 Sother (Specially occurred	A 63 piec		
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DHMH 17 Rev 1/2001

Registrar

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8:30 a Thomas Apr 24, 2008 Horace Harris /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Laurel 11703 Tuscany Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/28/1945 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 6. Sex Days Hours 1 □**X**M 2 □ F Yrs. Íllinois Director 350-36-1324 62 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11703 Tuscany Drive 20708 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Instit if item 27 is marked other than "natural", or Items 233 mit: if item 27 is marked other than "natural", or thems Lay or other traumatic event, the Medical Examiner must up or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Ricks Horace T. Harris Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11703 Tuscany Drive Laurel, Maryland 20708 Constance Harris Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
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any Injury or ot 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 04/28/08 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature et Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part1. Exper the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Metastatic years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has t page 2 s autopsy death? 1 ☐ Yes 2 ☐ No performed certificate 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Ph.D. 2008 24,

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Johns Hopkins 401 N. Broadway Balto Ind

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Medical

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29b. Signature, and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. AGNES HOSPITAL STARBAN, M.D 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State APR 29 Registrar DHMH 17 Rev 1/2001

Lelear, M.D

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0066262

BALTIMORE, MD

29d. Date signed (Month, Day, Year)

900 CATON AVE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year ames 1910 PM 2663 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins
5. Social Security Number Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) April 27,1951 If Under 1 Year | If Under Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F 217-54-2185 56 MD Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director MD Baltimore 1 ☐Yes 2 TXNo Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 Virginia Avenue 21221 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Manital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify \$ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Moving & Storage 4yrs permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygid Important; If item 27 is marked other i any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward H. Ikena Iva Rosemary Tutchton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Ikena Miller Baltimore MD 21221 504 Virginia Avenue Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 4/29/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen e 22. Name and Address of Facility 22. Name and Address of Facility 300 Mace Ave. Bac Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Staphylococcas /Medical Due to (or as a consequence of): **Examiner** branchopneumonia Ventilater-associated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Intraventricular Cevebral Blezon certificate be executed Intracerebrou burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 iver cirrhasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown page 2 should Completed Dilated Cardiamyopath 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No certificate has autopsy performed? heart Division or Vital congestive 1∐ Yes 2 🗆 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No
27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2

State Registrar ND

ddress of person who completed cause of death (Item 23a) (Type, Print)

WOLFE STREET, BALTILORE MD ZIZPS

31. Date filed (Month, Day,

32. Registrar's Signature Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month JOHNSON **Physician** 1045 AM NORMAN APRIL 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY Baltimore Kehab KavenWood NUISING 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 M 2 □ F Hours MARYLAND 220-14-521 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No MD BALTIMORE Director BALTIMONE CITY 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21201 USA SUI WEST FRANKLIN STREET Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: BLACK 2 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within : ent of Health and Mental Hygiene. nt: If item 27 is marked other than "n ny or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION ARPENTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chughyan ころくろのろん 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8325 WINDSOM MILL RODS BALTIMOREMD 21201 SHARO-> FURD / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS PELISTRA AFTIL 29 DOES HANOUER 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility
MATCHY LIFTS THE STRY
7522 CONNELLEY DRIVE, STEP, HUNDUR, MD 21076 21. Signature of uneral Servi Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Due to (r as a consequence of): disease or condition resulting in death) /Medical ple Sequentially list conditions, it is a property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 8 detached 9☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

þ P.0. Division or Vital Records,

Maryland 21215-0036

Saltimore,

Physician Examiner To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Amotory Nacom MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phin Street NAREM, 501 Dal 140 AMATUN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2008 138146 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

DHMH 17 Rev 1/2001

Registrar

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Licensee	150	1	7	22. Name ar		,	uner	al Service	PA					
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	V		30. Name and address	s of person who But, n	completed cause of d	eatn (Item 2)	ca) (Type,	+ BAR	Bo W	20.)	1220			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rose Kirkpatrick Μ. /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and nu Examiner Itimore Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) FEB 3 1933 If Under 1 Year | If Under 24 Hrs. **Funeral** Min. 1□M **X**□F 75 FEB Maryland Director 215-30-2374 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Funeral Director PA York Stewartstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19 Locust Street 17363 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 Bindery Supervisor Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance I Sichette Helen Graziano Luigi 2 Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Sichette - brother 19 Locust Street, Stewartstown, PA other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/26/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williams ²² Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 No 1 ☑ Inpatient 2 ER/Outpatient 3□ DOA 2 this 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 Ö Δ. or Vital Records, within 24 hours aller death.

To the Funeral Director: A er completely filled in by the furers Division To the Hospital

人 / ドレオヤバス人 Baltimore, Maryland 21215-003

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:CL PM 25 Marilyn Anna Knapp 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | October 24, 1924 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 83 Yrs. 218-12-4994 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural" or ftems 23a or 28a-f show any Injury or other traumatic event. the Mentical Evanning American and Injury or other traumatic event. 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. Baltimore 1 ☐Yes 2 No Nottingham Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4300 Cardwell Avenue 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Whi te Be Completed by 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marquerite Zeberlien Henry Schlee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Dobbins Lane Pasadena, MD. 21722 Karen Knapp/ Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Moretandamentoral 04/29/08 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 2 a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
36 kours Immidiate Cause (Final septic Shock **Physician** resulting in death) /Medical Due to (or as a consequence of) 5 days Examiner pneumonia Sequentially list conditions, tony, but any cause in the Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LLRINARY TRACT INFECTION 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed atrial Fibrillation HEGRI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed?

1 Yes 2 No Division or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatiely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours all To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 04/25/2008

State Registrar 31. Date filed (Month, Day, Year)

APR 2 9 2008

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMALITAN HOSPITCA NATALITY HOSPITCA NATALITY HOSPITCA

32. Registrar's Signature

Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician /Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
1 - For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2					13852	
1. Decedent's Name (First, Middle, Las LOULS' Kak	Pos SR			2. Date of Death Month Death		3. Time of Death	
4a. Facility Name (If not institution, give	street and number)	al 4b. City	Town, or Location of Death	2 40	c. County of Death	1	
5. Social Security Number 6. Sec	T • T	8 6 Yrs. If Under	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year 12/24/19	') Cot	pplace (State or Foreign Intry)	
Usual Residence of Decedent 10a. State 10b. Counfy MD Baltimo	y, Town or Location				10d. Inside City Limits 1 □ Yes 2 ☑ No		
10e. Street and Number 14 Treeway Court Apt. 2A		10f. Zi	10f. Zip Code 10g.			Citizen of What Country?	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	U.S. 13. Was Dece	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - Amer Black, White Specify: Whi	, etc.	
15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life. DO NOT I	ork done during most of wor	king BG	Kind of Business/I	ndustry	
17. Father's Name (First, Middle, Last) Louis Kardos, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Fannie Horvath							
19a. Informant's Name/Relationship (Type. Print) Mrs. Julia Kardos/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Treeway Ct. Apt. 2A Towson, MD 21286							
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Mo	Place of Disposition (Na cemetery, crematory or DSC HOLY RE Cenetery	other place) edeemer 05/	Date 20c. I 01/08 Ba	ocation - City or 1timore		
21. Signature of Funeral Service Licen		Évans	Harford Rd				
23a Part1. Enter the disease, or complete ck, or heat wilure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the decone cause on each line. a. Due to (or as a conse	Vasadar	de of dying, such as cardiac Acciden			Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b						
that initiated events resulting in death) Last	c						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						very Day Year	
Part II. Other significant conditions o	ontributing to death but not re	esulting in the underlying	cause given in Part I.			the cause of death?	
				24a. Was an autopsy performed? 1 Yes 2 N	prior to death?	topsy findings available completion of cause of	
25. Was case referred to medical examiner?	Heapitali			th (Check only one)			
1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	Hospital: 1 Mainpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No						
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	home, farm, street, facto			Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, death occurre	d at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)	

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

State

Registrar

29c. License number D63882 29d. Date signed (Month, Day, Year) April, 28,2008

30. Name and address of person into completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Bird British 4 Pinels British 21239 Meli S. Registrar's Signature

31. Date filed (Month, Day, APR 2 9 2008

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day April 25, Robert Dixon Kagle 2008 4:24 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown | Hours | Min. | S. Date of Birth (Month, Pay, Year) | 1927 Northwest Hospital Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 217-26-7340 81 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore XXYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 Mause Ave. 21225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes XIXNo Specify. Specify: White XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Steam Fitter Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Lee Kagle Alice Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonya T. Welsh / Sister 233 Sacred Heart Lane; Reisterstown, MD21136 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Glen Haven Memorial Park XXBurial 2 \square Cremation 3 \square Removal from State 4/29/08 Glen Burnie, MD 4 ☐ Donation 万 ☐ Other (Specify) 21. Signature J Fun eral Service Licen 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 troken 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hespiratory disease or condition resulting in death) Due to (or as a consequence of): P. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown rena 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No autonsy perforn anemia 2 2 10 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

show

d other than "natural", or items 23a or 28a-f shov event, the Modical Exemples mass be notified at

72 hours after death with

12 should be filed within 7 h and Menta! Hygiene. 7 is marked other than "n

traumatic

permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.

afy.

1 and 2 should be
4 Health and N

Baltimore, Maryland 21215-0036

be executed burial-transit and Box 68760. physician the as aftending use for P.O. the Division of Vital Records,

been signed by t should be detach has e 2 s page

certificate director this After th funeral

or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Physician/Medical 2 Completed Be မှ Certification:

104

To the within 2,

State Registra

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brid

27. Manner of Death

10 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 9

5 ☐ Pending Investigation

6 ☐ Could not be

determined



28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APZIL Physician Year ADELE MARY DILIELLO LEE 440 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ARINCE GEORGES SHANTY HOME AURUEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F Months Days Hours Min 213-32-5905 MARYLAN Director DECEMBER 9 1933 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at MD 1 Yes 2 No Director GRUENBELT ARINGE WEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō EMPIRE USA Funeral [20770 23a death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BUSINESS Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DILIELLO GRANESE THERESA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD, MYERSVILLE, MD 21773 9404 HARMON CTULIE MARIE JENKING / DAULHTHR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANOUER 4 □ Donation 5 □ Other (Specify) 4/29/08 ARDENTCREMATOR 21. Signature of Feneral Service Uc nsee 22. Name and Address of Facility 91016 CHIPTICHAN M GENERAL SOLECE COSTANCIO 2 CHECKA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUMANY NOS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it is a sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 □ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ≥ □ No 1 ☐ Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 2 ☐ No 2□ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Certification: To 1 TYes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

State Registrar

0

31. Date filed (Month, Day, Year)

APR 2 9 2008

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03048 2008 13855 State of Maryland / Department of Health and Mental Hygiene Hugo Enrique Lopez-Medina Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1006 hrs April 19, 2008 HUGO ENRIQUE LOPEZ Μę Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hvattsville 2300 Calvert Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Davs Hours Months Director 23,1970 37 April Salvadbr NONE 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No Prince George's Hyattsville 28a-f show Maryland other than "natural", or items 23a or 28a-f sho Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 EL SALVADOR 2300 Calvert Street 14. Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes 1X_ Yes 2 No specify: SALVADORIAN Hispanic Specify: f Yes, Give Year 3 Widowed 4 Divorced ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction, Co. Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Atilio Lopez Maria Ester Medina 2121 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 20783 Marvland. Sister) 2300 Calvert St, Hyattsville Ladis D. Medina 20b. Place of Disposition (Name of cemetery, San Antonio Silva 20a, Method of Disposition crematory or other place) Cemeter Burial 2 Cremation 3 X Removal from State 05/3/08 San Miguel. El Salvado San A ntonio Si<u>lva</u> Other Specify 22. Name and Address of Facility Santa Cruz Funerales Latinos, INC 21. Signature of Funeral Service Licenses 600 Kennedy Street N.W.: Washington. 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and failure. List only one cause on each line. Death ledical a Multiple Gunshot Wounds Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed and Physician/Medical **AMENDED** the attending physician ed for use as the burial -UNPENDED 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Ś Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy death? performed? certificate has page 2 s 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: this certifial director, 25. Was case referred to medical Division of Vital Be Other; Nursing Home 5 Residence 6 ✔ Other: Scene examiner? ER/Outpatient DOA Inpatient 2 1 Yes 28d. Describe how injury occurred 28a. Date of Injury After th 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot by police Apr 19, 2008 Certification: 0959 hrs 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Pending Director: d in by the f Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 2300 Calvert Street, Hyattsville, MD Suicide determined (Specify) Home 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 20, 2008

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

Laron Locke MD.

31. Date filed (MAPIR D.2. YEP) 2008

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death APRIL **Physician** 2008 05:50 PAULINE AUGUSTINE LENNON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month Day, Year) 02/21/1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min NORTH CAROLINA 1 □ M 2 F 81 215-24-5001 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 □ No MD N/A BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō death with 5300 FERNPARK AVENUE 21207 USA 23a Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: BLACK 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify. 2 3 Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
COOK 16b. Kind of Business/Industry US GOVERNMENT and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY ADMN. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NEIL FERGUSON LOULA DAVIS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. CLARINA NELSON / SISTER 5300 FERNPARK AVENUE, BALTIMORE, MD 21207 20a. Method of Disposition
1 Disposition 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date WOODLAWN CEMETERY 4/29/08 BALTIMORE COUNTY, MD 4 ☐ Donation 5 ☐ Other (Specify) HOWELL FUNERAL HOME 21207 22. Name and Address of Facility of Suneral Service Licen 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Approximate Interval Between Onset and Death Payl Enter the disease, or complications that caused the shock, in heart failure. List only one cause on each line eath Do not enter the mode of dying, such as cardiac or respiratory arrest, ause (Final **Physician** disease or condition resulting in death) UNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner W pa burial-tran Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending p as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation s after dea... 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2.

State Registrar

MAIN STILLET 2. Registrar's Signature 31. Date filed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

REISTENSTOWN MO

29d. Date signed (Month, Day, Year)

23 2008

Registrar DHMH 17 Rev 1/2001

State

University Parknay

Baltimore MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

Vi'T

APR 29

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** SYLVIA Ам LANDSKRONER 2008 11:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME CATONSVILLE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/05/1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months Days Hours Min. 069-01-0371 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ire. Medical Exempter must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 NORTH ROLLING ROAD 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 □Yes 2 No Be Completed by If Yes, Give Year or Dates: Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS EXAMINER SOCIAL SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **PROPER** HARRY MOLLY GOLDSTEIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET DALY / DAUGHTER 1051 WEST US BUSINESS HGWY 83, DONNA, TX 78537 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Nemoval from State ETERRORIAL GARDENS 04/29/2008 BOYNTON BEACH, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S **Physician** DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a, Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year) APR 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

UMA



BUSINESS

DHMH 17 Rev 1/2001

CENTER

29c. License number

D0059107

DRIVE REISTERSTOWN

29d. Date signed (Month, Day, Year)

MD 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) APRIL 2008a **Physician** 26 10:10 P M S LEVY NATALIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE N/A KESWICK MULTICARE CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07/16/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F 84 218-14-6050 rector Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5906 EASTCLIFF DRIVE 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KAPLAN STRAUSS **ESTHER** LOUIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5906 EASTCLIFF DRIVE, BALTIMORE, MD 21209 MERRILL LEVY / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place)
HEBREW YOUNG MEN 20a. Method of Disposition
1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 04/28/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Malf Len 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** fig Years Jemen /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Vear 4□Pregnant at time of death a∏IJnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Medical

10

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

29c. License number 00061199 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 North Charles St. Suite 209 Touson MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year)

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 30 POEDAY MENT STATE AND Wental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** 0 /Medical 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) Hartor Grace If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Months Days Director filed within 72 hours after death with the Marylend Hygiene. Ither than "natural", or Items 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. tem 27 Ie marked other than "natural", or Items 23a or 28a-f ehov other traumatic event, the Modical Examinar must be notified at 1₽Yes 2□No Director more 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Ses 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Specify:Bla Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Default Pages 1 and 2 should be be Department of Health and Mental H. Important: if item 27 ie markers any injury or other Be 2 19a. Informant's Name/Relationship (Type, Print) aug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 St Regi 5 Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Conetey 21. Signature of Funeral S. vic. Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIL Physician Shock DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b performed? Yes 2 No 2 1 🗌 Yes 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3□ DOA After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) any manner stated. 29b. Signature and title o 29c. License number 29d. Date signed (Month, Dey, Year) 0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harford Memorial Hospital Jason Michael Birnbaum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland	/ Depa	artmen rtificat	t of He	ealth a Death	and Me		iene2 () ()	8 386	1
			Decedent's Name (First, Middle, Last)								2. Date of Deat	h	3. Time of Death	_
	Physici /Medic		Joyce Mauldi	n							April	25 2008	8 6:30 a M	
)	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or	Location o		•	4c. County of		
			Harford Memorial H	ospital			Hav	re de	e Gra			Harfor	rd	
	Funeral Director		5. Social Security Number 6. Sex 220−50−2627	7. A	ge (In yrs. Ias 56	t birthday) Yrs.	If Under Months	Days	II Under a	Min.	8. Date of Birth (Month, Day, JUN 16	1951 Ma	Birthplace (State or Foreign Country) aryland	
	Du 3		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	_
	fanyle sho	5	MD Harford										1 ☐ Yes 2X No	
	28a-1	Director	10e. Street and Number		ADE	erdee	10f. Zip	Code			11	0g. Citizen of Wha	at Country?	_
	With 3a or		22 Alton Street					.001				USA	· ·	
	death me 2	Funeral		2. Was Deceden		13.			spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	14. Race -	American Indian,	-
Q	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or Iteme 23a or 28a-f show int, the Musical Examinar must be notified a		1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give			lYes, spe 1 ☐ Yes		s, Mexican Specify:	, Puerto F	Rican, etc.)		White, etc.	
21215-0036	ural',	d by	3 ☐ Widowed 4 ※ Divorced	Year or Dates:			1 1 1 1 1 1 1 1	2431 NO	эреспу.			Specify:	White	
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Ś	8 50	٥	Part II. Other significant conditions cont	ributing to death ΔD	but not resulti	ng in the ui	nderlying o	ause give	n in Part I.		23e. Did tob		ite to the cause of death?	
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DIVISION	4 - 0 9	If Ca	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ir	jury - At home	e, farm, str	eet, factor	y, office		2	8l. Location (St	reet and Number of	or Rural Route Number,	_
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	54 T 9	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	er: On the basis of	ot examination	edge, death and/or in	occurred vestigation	at the time	e, date and inion, deat	d place, a th occurre	nd due to the ca	use(s) and manne ate and place, and	er as stated. due to the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner s	(a(00.			c. License				9d. Date signed (A		
	F \$ F 8		1 all		1	- a.l.	1.00	01-	207	7		1 1	75 7000-	
		-	30. Name and address of person who com	pleted cause of	death (Item 2)	3ay (Type	Print)	100	701	-		WIL	5,000	_
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2	Sta		31. Date filed (Month, Day, Year)	32 Regist	rar's Signatur	0	W -	V				1		_
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Physician /Medical Examiner

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Completed

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Certification: To

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event once.

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-trar for page 2 director, or Attending 24 hours after death e Funeral Director: filled in by the

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

within 2 To the

Hospital

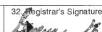
31. Date filed (Month, Day, Year) APR 2 9 2008

EID ALMUTAIRY, M.D.,

29b. Signature and title of certifier

4 THomicide

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D66184

10724 LITTLE PATUXENT PKWY., SUITE 200, COLUMBIA, MD 21044

29d. Date signed (Month, Day, Year)

2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician Month 26 2008 elena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsul If Under 1 Year | If Under 24 Hrs. 110 altimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** Year) 1□M 2☑F Months Hours Min. Days 220-09-2556 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, the Modical Exercites in at Leanstitied at another. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director mD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7680 2072 Koac Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Specify: 3 分Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home raker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be alter -reeberger Henrietto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald meNeil 7680 Kindler 1110 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 30/2008 4 ☐ Donation 5 ☐ Other (Specify) altimore emeter 22. Name and Address of Facility

- vons Funeral Chapel + Cremation Services Parkville 21. Signature of Funeral Service Licensee Stacia 18800 Harford Road Parkville MD 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disease **Physician** theroscler DZBVG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ohera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner sician and burial-trans Zheim Live to (or as a consequence of): Box 68760 Hospital or Attending Physician: The law requires that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yes 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 100 Vital 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 WiNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 24 hours after deat e Funeral Director: within 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

D38762 04-20

L MD FACE

30. Name and address of gerson who completed cause of death (Item 23a) (Type Print) Shoron

Balt. more Md. 21239

2008

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

/Medic		Helen E. Moore						Apri1	21,	2008	5:30	Ам	
Examin		4a. Facility Name (If not institution,	give street and numl	ber)		4b. City, Town, or	Location of Death		4c.	County of Death			
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Funeral				. Age (In yrs.	last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth (9. Birth	iplace (State or intry)	Foreign	
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Aents Aents rked tlc e	2	Miles H. Knowle	S				Elizabet	th D. P	earso	n			
shot nd N ma	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Ma	iling Address (Street a	and Number or Ru	ral Route Num	ber, City or	r Town, State, Zi	ip Code)		
nd 2 should be filed within 72 hours after deat aith and Mental Hygiene. 27 Is marked other than "natural", or Items ? r traumatic event, the Medical Examiner mu		Pamela Moore/ D	aughter		1570	01 Alameda	Drive Bo	owie, M	D 207	15			
Hea Hea tem	y) (6	20a. Method of Disposition		20b. F	lace of Dis	position (Name of	. !	Date	20c. Lo	cation - City or T	own, State		
ages nt of :: If If		1 ☐ Burial 2 🖾 Cremation		tate c	emetery, ci Metro	rematory or other place opolitan	θ)				***		
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permi Depar Impoi any ir once.		21. Signature of Funeral Service L	.icensee •		- (22. Name and Addres					al Home	:	
<u></u>		When A	neth			16000 Anna _l				20715			
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/Medical		resulting in death)	a. Due to (o	r as a conseq	uence of):	10 eu	corne	coer	ne	che	22"	enu	
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th ce endi	Jue /	23b. Was decedent pregnant	23c. If yes, outco	ome pf pregna th 2□Feta	ancy Ideath 3	3 □Ectopic pregnancy			2	23d. Date of deliv			
dear e att	ic.	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nt at time of d		Other (specify)			į	Month	Day Y	'ear	
	2	9 ☐ Unknown	9□Unknov	vn									
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has e 2 s	ם							24a. Wa aut	opsy	prior to c	topsy findings a ompletion of ca	use of	
	Ö							1 Yes	formed? 2 Z No	death? 1 ☐ Yes	2□ No		
certificate ector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)				
nyslo	2	1 ☐ Yes 2X No	Hospital: 1 □ Inp	patient 2	ER/Outpat	ient 3 DOA Othe	er: 4 🗆 Nursing H	ome 5X Res	sidence 6	6 □Other (Spec	ify)		
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Atte dea	Ęį į	3 Suicide 6 Could no	200. Place o	of injury - At ho	me, farm,	street, factory, office		28f. Location	(Street and	d Number or Ru	ral Route Numl	ber,	
affe Dird	Certification:	4 ☐ Homicide determin	building	g, etc. (Specif	у)			City or 16	own, State,)			
splta ours neral filled	0	29a. Certifier 1X Certifying	Physician: To the b	est of my kno	wledge, de	eath occurred at the time	ne, date and place	and due to th	e cause(s)	and manner as	stated.		
Hos 24 h Fur stely	ledical			sis of examina		investigation, in my o)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Mec	29b. Signature and title of certifier	and maille	viatou.		29c, License	number	<u> </u>	29d. Dat	e signed (Month	Day Year)		
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10		30. Name and address of person w		of death (Item	28a) (Typ	e, Print)	7 4	1	0 11		14.4		
(-		GloRIA DAM	ien, mi	2 72	4 /	raiden C	noce t	ane 1	Ball	tmore	MdZ	1228	
Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signa	nture	19 -							
Registr	ar	APR 29	ZUU8	Carrie A	1 8	0246							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Elizabeth Killian Musser 12:30 PM April 23, 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1055 Elm Road Baltimore Arbutus If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F Months 169-24-6487 78 19, 1929 Jun. Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 Elm Road 21227 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates; 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 X No Specify: Specify White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. Vernon Binkley Mamie Rohrer Killian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger J. Musser - Son 8801 Links Bridge Rd., Thurmont, MD 21788 20b. Place of Disposition (Name of McTTLINGET Systematory or other place) lethod of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 XRemoval from State 5 ☐ Other (Specify) Mennonite Cemetery 4-25-2008 Lancaster, PA 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, DM 21227 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, BSTRUCTIVE DISCASE HRONIC YULMORIARY Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be r

Baltimore, Maryland 21215-0036

r 28a-f show notified at

Director

Funeral

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Box 68760.

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Division or Vital Records,

page 2 s

certificate

Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

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State Registrar SABA SITCIKH

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32. Registrar's Signature

23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTGRY CORONBRY 1 Mayes 2 No 3 Probably 4 Unknown PERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed: ESSGNTIA HROMBOLYTOSIS 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🞽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 042680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NATIL PIKE, 40 ELLICOTT

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 13866

		1- For State Cell Registrar	rtificate o	f Death		Re	g. No.	
Physicia Medical Exami		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Year	3. Time of Death 0815 hrs
)	ilei	Mary Ann Mayo 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea	April 18, 20	4c. County of Death	
4		Johns Hopkins Bayview Medical Center		Baltimore	_		N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I 1 M 2 F 4 0	•	If Under 1 Year Months Days		s. 8. Date of Birt n. July	15,1967 Co	thplace (State or on Maryland untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Locat	tion			-	10d. Inside City Limits
* . *	or	Maryland N/A B	Baltimo	ore				1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	I Director	10e. Street and Number 4610 Chatford Avenue		10f. Zip Code 21206		10	og. Citizen of What Cou USA	ntry?
E : 5	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes (Sive Year or Dates:		as Decedent of His Yes, specify Cuban	Mexican, Puer		14. Race - Amer White, etc. Specify: Bla	ican Indian, Black,
hours :	ed b	15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupat nost of working life.			16b. Kind of Business/	Industry
036 thin 72 ne than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade	Nurse	e Assist	ant		Private	Industry
21215-0036 uld be filed within 72 hours at Mental Hygiene marked other than "natural cevent, the Medical Examin	Be	17. Father's Name (First, Middle, Last) Lawrence Everette, Jr.	-	2	Shirle	ne (First, Middle, N Y Veney		
e, MD 2121 1 and 2 should be fi Health and Mental item 27 is marked	To	19a Informant's Name/Relationship (Type, Print) Michael Mayo/ Husband	4610	Chatfor	rd Aver	nue Bal	timore, M	
								, Maryland
Balt permit Depart Import injury		21. Signature uneral Service Life e	22. I 5.2	Name and Address 240 Reis	^{of Facilit} Cha stersto	atman-H own Rd	arris Fun Baltimore	eral Home ,Md 21215
Physician	_	23a. Part I. Enter the discusse, or complications that caused the death failure. List only to e cause on each line.	1. Do not enter f	the mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
'Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a Hypertensive ather		cic cardiov	ascular d	isease		Death
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):	 				
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	of):					
cuted and transit	ш	d						
760, icate be executed physician and the burial - trans	/Medical	X UNPENDED AMENDED 7, perME.gg	879 . 5/6/	′08 TT				
Box 68760, s death certificate be the attending physicied for use as the buried as the buried for use as the b	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of december 25c.	gnancy 2 Fe	etal death 3 [ther (Specify)	Ectopic preg	nancy	23d. Date of deliver Month	y Day Year
that the de ned by the detached i		Part II. Other significant conditions contributing to death but not r	resulting in the	underlying cause g	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
s, P.	ed by					1Yes	2 No 3 Pro	bably 4 🗹 Unknown
ords, aw requii as been s	Completed					24a. Was autop	sy prior to	utopsy findings available completion of cause of
tal Recitan: The Licentificate hector, page	Com					1 ✓ Yes	rmed? death? 2 No 1 ✓ Y	es 2 No
ital sician: s certifi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatien	1	of Death (Chec		Residence 6 Othe	
n of V ding Phys After thi funeral di	n: To	1 Yes 2 No Indicate of Injury 27. Manner of Death 28. Date of Injury (Month Pay Year)	28b. Time of		y at Work?		how injury occurred	
sion ttendii death. ctor: A	atio	1 X Natural 5 Pending 2 Accident Investigation		1 \ \	es 2 No			
Division of Vital Records, P. pital or Attending Physician: The law requires th ours after death. teral Director: After this certificate has been signe filled in by the funeral director, page 2 should be de	Certification:	3 Suicide 6 Could not be determined (Specify)	ome, farm, stre	eet, factory, office b	uilding, etc.	28f. Location (S or Town, S		ural Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a						
2 1 × 1 0	Me	and manner stated. 29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
2.1.		hy w, hrs		O.C.I	M.E.		April 19, 2008	
expera		 Name and address of person who completed cause of death (Item Ling Li, MD Assistant Medical Examiner 111 		et, Baltimore,	MD 21201			
State 31. Date filed (Month, Day, Year) Registrar APR 2 9 2008 Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Catherine 2008 04 4:50 p /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 746 Bethnal Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ I Months Days Hours Director 214-20-7258 Feb 25, 1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if them 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 □**X**es 2 □ No Directo Maryland **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 746 Bethnal Road 21229 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 ģ Specify. 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Human Res. Social Service Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Griffin Herman Griffin မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 East 33rd Street-Apt. 308 Baltimore, Maryland 21218 Sarah Anthony Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 04/30/08 Pikesville, Maryland Druid Ridge Cemetery uneral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimere, Md 212 shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertension **Physician** /Medical Due to (or as a consequence of): Examiner perlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> GERD , 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has Carotid 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2|XNo 1 🔲 Inpatient ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of e Hospital or Attending PI 24 hours after death. e Funeral Director: After the letely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065934 SumadMd 30. Name and address of person who cover eted cause of death (Item 23a) (Type, Print) Q 4660 Wilkens Ave #100; Baltimore MD 21229 Mode Seema A. 31. Date filed (Month, Day, APR 2 Registrar's Signature Year) State Registrar

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57. YV.	Ш	 1 - State Registrar 1. Decedent's Name (First, Middle, La 	st)		Certi	ificate of L	Jeath	2. Date of De			3. Time of Death			
Physic /Med			Ge	orge McF	₹ae			APRIL	V G		9:10 PM			
Exam		4a. Facility Name (If not institution, given				4b. City, Town, or	Location of Death			County of Dea	ith			
			nd Baptist Ag	jed Home			Balti	more			N/A			
Funera Director		5. Social Security Number 6. S 240-34-2168 Usual Residence of Decedent	Sex 7. A I ■ M 2 □ F	Age (In yrs. last birth 78		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month Da	rth a <i>y, Year)</i> 1, 192	9. Bir	thplace (State or Foreign ountry) No. Carolina			
Maryland f show ed at	JO.	10a. State 10b. County	v/A	10c. City, Town	or Loca		altimore				10d. Inside City Limits 1 Yes 2 No			
the I	Director	10e. Street and Number			1	10f. Zip Code			10g. Cit	izen of What Co				
ath with 23a or	ral D	2801 Rayner Avenue					21216	_		U.S				
ITYIANG Z1Z15-UU36 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	? ≹No		s Decedent of Hi 'es, specify Cuba Yes 2 XNo	spanic Origin? (S _I n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, Whit Specify:				
72 h	Completed	15. Decedent's E (Specify only highest gre	ducation (de completed)	16a. [Deceder Give kir	nt's Usual Occupa nd of work done d	ution uring most of wor	king	16b. Ki	ind of Business	/Industry			
within ene.	dmo	Elementary/Secondary (0-12)	College (1-4o	5+)	life. DC	_	borer			Construction	on Company			
iffed Hygi Other ent, tl	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	, Maiden	Surname)				
arylan should be nd Mental marked o	To B	Willian	McRae							McRae				
y, Maryland 2121 and 2 should be filed within eath and Mental Hygiene. n 27 is marked other than " ier traumatic event, the Mec		19a. Informant's Name/Relationship (Mildred Horn	Type. Print)	19b. I			nd Number or Ru ak Avenue E				Zip Code)			
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any hijury or other traumatic ev ence.		20a. Method of Disposition 1		20b. Place of Cemetery		on (Name of tory or other place Zion Cemete		Date 04/29/08		cation - City or Lansdown	Town, State e, Maryland			
permit. Departri Importa any inju		21. Signa ure of Funeral Service Lice	11 56	Tao	22. N	lame and Address		eral Service	P. A.	17				
Physician		Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Immediate Cause of nal disease or condition resulting in death) a. Coval or carry thormics Due to (or as a consequence of):												
/Medical Examiner			b. Hy	s a consequence of		House	d13-e41	æ			15 MINUS			
ecuted and -transit	Examiner	Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Hy	s a consequence of	7			204-3						
rificate be executed by yellow and as the burial-transit	Aedical E										5415			
death ce	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2		ctopic pregnancy ther (specify)			2	23d. Date of del Month	livery Day Year			
requires that the een signed by the nould be detached.	b	Part II. Other significant conditions of Demential P	ontributing to death	but not resulting in t			n in Part I.			se contribute to	the cause of death?			
The law requires t ate has been signe page 2 should be c	Completed							24a. Was autor perfo 1∐ Yes		death?	utopsy findings available completion of cause of			
VILCIIII Iclan: T Sertificat ector, pa	Be (25. Was case referred to medical examiner?					26. Place of Deat							
Physic rthis c	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat				4 Minursing Ho	ome 5 Resid	dence 6	6 □Other (Spe	cify)			
Attending For death. ector: After by the funera	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	14	ay Year) Inju	ıry		at ? es 2 □ No	28d. Describe I	how injur	y occurred				
ital or Attend Irs after death. ral Director: /		4 ☐ Homicide determined	building, e	jury - At home, farm tc. <i>(Specify)</i>				City or Tov	vn, State,)	ıral Route Number,			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.												
To with	2	29b. Signature and title of certifier				29c. License	number 30494			e signed (Mont /୯୫/୧୯				
\		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	rpe, Prir						3			
Sta	ite	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	1	40					.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year August Raymond Machen 2008 April 26 9:05 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Blakehurst Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F 219-18-5183 87 July 24. 1920 Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2¥ No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road, Unit 140 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Raymond Machen Olive Rebecca Hummer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sloan / Attorney St. Paul Street, Ste. 1500, Balt., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Hilltop Service Corp. 04-29-2008 4 □ Donation Towson, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. 23a, Part1 Po not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) reumonis Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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certificate

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To the Hospital or A within 24 hours after To the Funeral Direct

Attending [

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Physician/Medical

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Completed

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Certification:

Medical

attending physician

certificate be executed

Box 68760,

P.O.

Division or Vital Records,

Physician

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Examiner

Funeral

Director

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Department of H Important: If ite any injury or ot

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Pages 1 and 2 should be filed within 72 hours after

3altimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last

3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy pertorm

1 Tyes

No.

2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25.	examiner?	
27.	Manner of Death	
	1 X Natural	5 Pendin
	2 Accident	investig

5 Pending investigation 6 ☐ Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year)

person who completed cause of death (Item 23a) (Type, Print)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 TYes 2 TNo

Other:

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 ☐ Suicide

4 ☐ Homicide

31. Date filed (Month, Day,

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N Charles St, Bultmore,

State

Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day TERESA MATOS 26, 2008 APRIL 5:46 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 728 OLD WESTMINSTER PIKE CARROLL WESTMINSTER Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2**X** F 121-24-5914 88 Director 10/15/1919 PUERTO Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 728 OLD WESTMINSTER PIKE USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 MYes 2 No Specify: PUERTO RICAN Specify: HIS PAN 12 þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, I'm Magny injury or other traumatic event, I'm Magny injury or other traumatic event, I'm Magny injury or other traumatic event, I'm Magnos. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DIAZ CANDIDA ဂ္ FIGUEROA 19a. Informant's Name/Relationship (Type. PrinDAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED MATOS-DEJESUS 2434 PROSPECT AVE., APT. <u>1c, BRONX, NY 10458</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) CEM. RAYMONDS 5/1/08 BRONX, NEW YORK eral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. □Yes 2 □No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) Hospital 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending investigation Injury 1 ☐Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitar S. within 24 hours after To the Funeral Dir 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 00050763 30. Name and address of person who completed cause of ten Rd Suite 120 Westminster mbans Year 2 State 9 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month VUOLYIS 0252 AM **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 12-22-1933 9. Birthplace (State or Foreign Country)
Rutherforton NC. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 578-48-3357 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 □ No Anne Arundel Director evern 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 76 U.S.14 Deerfield 21144 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12yr Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn Bohannon Dickey lecumsely မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7703Stanmore Dr. Beltsville, IMD 20705 Smith lawanda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 13300 Baltimore AVE Laurel MD. 1 Murial 2 ☐ Cremation 3 ☐ Removal from State MD Nat Memorial Park: 05-1-2008 4 ☐ Donation 5 ☐ Other (Specify) 8144PShur St.NW 21. Signature of uneral Service Licensee TRI-State Funeral Services Washington DC 2001 w 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Implediate Cause (Final days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal dea 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) ၉ After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 1 Yes 2 No death. within 24 hours after death

To the Funeral Director: /
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prins Hospital, 600 North Wolfe St, Baltimore, MD, 21287 The Jinns 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dorothy Marie Miller рм 04/23/2008 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens-Charlestown Care Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1914 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-10-8602 Director Baltimore, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director MD Baltimore 1 ☐ Yes 2 ☐ No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe 719 Maiden Choice Lane 23a 21228 United States must death Funeral 12. Was Decedent Ever in U.S. Armed Forces? or items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or item edical Examiner r Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: White à 3 Widowed 4 ☐ Divorced ed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complete (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Insurance traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be James E. McCloskey Dora Yenter ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra James McCloskey (Brother) 2403 Forest Edge Court, Odenton, Maryland 21113 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 04/28/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Justive cardionwood **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760, physician Physician/Medical The law requires that the death certificate the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the g 9□Unknown signed I Part II. Other significant conditions contributing to death but not resulting, in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has autopsy perform 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 | Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA o this 27. Manner of Death 28a. Date of Injury After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending (Month, Day Year) 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

Lansin

Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

noue Came Culouwille,

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of	Marylan	id / Depa	artment of I rtificate of	dealth and Death	d Me	ntal Hy	giene	20	08	13873	
۳		7	1. Decedent's Name (First, Middle, Last)			tineate of	Death	2	. Date of De				3. Time of Death	
AL CA	Physici /Medic		Opal M. Oberly					A	Month pril 20), 20		Year	7:21 P M	
	Examin	er	4a. Facility Name (If not institution, give street and numb Prince Georges Hospital	er)		4b. City, Town, o		eath		1		of Death e Geoi	raes	
15	Funeral	_		Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H		. Date of Birt	th		9. Birthp	place (State or Foreign	
	Director		301-12-2524 1□ M 2\(\)F	85	Yrs.	Months Days	Hours Mi		(Month, Da anuary			Kansa	itry)	
	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	
	a-f sh	ctor	Maryland Prince Georges	Bow	ri e								1 ☐ Yes 2X☐ No	
	vith the	Director	10e. Street and Number			10f. Zip Code				_		/hat Cour	ntry?	
	leath v	Funeral	12319 Stonehaven Lane Apt S19 11. Marital Status 12. Was Decede	ent Ever in U	S 13 1	20715	dispanic Origin?	(Specif	y Yes or No		SA 14 Bace	- Americ	an Indian,	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Force 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced Armed Force 1 □ Yes 2 If Yes, Give Year or Date	es? [X]No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2【 No	Specify:	erto Rio	can, etc.)			k, White,		
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d 2	e filed Il Hygi other /ent, t	Be Co	17. Father's Name (First, Middle, Last)		1701101	ilako.	18. Mother's N	lame (F	First, Middle,					
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Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licensee M0 234	,	F	Name and Addre leck Funera 601 Sandy S	al Home, l		urel. N	larv1	and 2	0707		
	1185		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac	sed the death	n. Do not ente	er the <i>m</i> ode of dyi	ng, such as card	liac or r	espiratory ar	rest,			Approximate Interval Between	
V.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	diac Arr	hythmia								Onset and Death	
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89 ×	ertifica ing ph e as th	Medi	IF FEMALE:											
Вох	eath o attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	me pf pregna n 2 □ Fetal t at time of de	Ideath 3□	Ectopic pregnanc	у				23d. Date Mon	e of delive	Day Year	
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000	law require as been siç 2 should b	plete	Fracture Neck Femur (left) Statu	ıs Post	Interna	l Fixation			24a. Was a		24b. W	Vere auto	psy findings available	
<u> </u>	Fracture Neck Femur (left) Status Post Internal Fixation 24a. Was an autopsy find prior to completion death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)													
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Sior	endin sath. or: Aft he fun	atio	2 Accident investigation April 10	Day Year) ,2008	Injury 1338		k? Yes 2⊠No	S1	id out	of ch	air a	t nur	sing home	
Division or	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of building, Heartfie	injury - At ho etc. <i>(Specify</i>	me, farm, stre	eet, factory, office			City or Tow	n, State)		I Route Number,	
	spital neral y filled		29a. Certifier 1 Certifying Physician: To the be	st of my know	wledge, death	occurred at the tir	me, date and pla	ice and	due to the	called/e/	and mar	anor ae et	owie, MD ated. 20715	
	the Hc iin 24 h the Fu ipletely	Medical	(Check only one) 2 Medical Examiner: On the basis	of examinat	tion and/or inv	estigation, in my o	opinion, death oc	curred	at the time,	date and	place, a	ind due to	the cause(s)	
i	With To 1	Σ	29b. Signature and title of certifier	ett	2	29c. Licens		•	2				Day, Year)	
		-	30. Name and address of person who completed cause of	f death (Itam	23a) /Tune 1	D21883	5			Apri	1 21,	2008		
_	1		Hema P. Yadla, MD 9470 Apnapol				n, MD 2070	06						
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DHMH 17 Rev 1/2001

			for State Registrar	State of Mary		epartment of I <i>Certificate of</i>			giene Reg. No. 20	08	13874			
	Physic		1. Decedent's Name (First, Middle, I	Parsons				2. Date of Dea Month	ith _Day	Year	3. Time of Death			
	/Medi Examir		4a. Facility Name (If not institution, g	ive street and number)		2 /	or Location of Death	4	4c. County		800 PM			
	Funeral			haw Ave	yrs. last birt	1 -	Lindle If Under 24 Hrs.	8. Date of Birth	Balt		/			
	Funeral Director		213-20-3357 Usual Residence of Decedent	1□ x M 2□F		rs. Months Days	Hours Min.	(Month, Day	Year) 1, 1925	Countr	ace (State or Foreigh aryland			
	ryland how		10a. State 10b. County	100	. City, Town	or Location				100	d. Inside City Limits			
	the Ma 28a-f s	Director	Maryland Ba	altimore			Baltimore				1 Yes 2 No			
	23a or ust be r	ral Dir	4221 Kenshaw Avenu	e		10f. Zip Code	21215		10g. Citizen of W	U.S.A.	•			
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Lyes 2 No If Yes, Give Year or Dates:	1944 1946	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- Americar c, White, et				
15-	in 72 in "nat in "Medica	plete	15. Decedent's l (Specify only highest g	Education rade completed) College (1-4or 5+)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Bus		•			
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ary	2 should be f and Mental H is marked of aumatic ever	Ţ	19a. Informant's Name/Relationship		19b.	Mailing Address (Street	and Number or Rura	al Route Numbe	r, City or Town, S	State, Zip C	Code)			
	1 and 2 Health em 27 i		Annette G. Parsons W 20a. Method of Disposition		Dh. Place of	4221 Kenshav								
=	permit. Pages 1 a Department of Hee Important: If item any injury or othe		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	cemetery	n Forest Veterar	ce) is Cemetery	05/05/08	20c. Location - C	ngs Mill				
Ba	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Lice		en ·	22. Name and Addre		ral Service,	P. A.					
-		77.50	Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part1. Enter the risease, or complications that caused the death U o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart siture. List only one cause on each line. Approximate Interval Between											
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	certific nding p use as t	/Mec	IF FEMALE:	23c. If yes, outcome pf pre	anancv						J			
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S, F	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not	resulting in	the underlying cause giv	en in Part I.		oacco use contrib					
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Vital Records,	The lander	Completed	- 2 - Mype	Merene				24a. Was a autops perform	y pr ned? de	ior to comp eath?	y findings available pletion of cause of			
Vita	y sıcıan : the is certificate hε director, page	BeC	25. Was case referred to medical examiner?				26. Place of Death			⊒Yes 2	□No			
ō	r this ceral direction	1.70	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outp	patient 3 DOA Oth	4 LI Nursing Hor		ence 6 GOther					
ion	ending sath. or: Afte he fune	ation	1 Natural 5 ☐ Pending investigation			ury Wor	k? Yes 2 □ No	.cu. Describe no	w injury occurred	,				
Division or	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		t home, farn ecify)	n, street, factory, office	2	8f. Location (St. City or Town	reet and Number n, State)	or Rural R	Provide Number,			
	To the hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier 1 ☐ Certifying P (Check only one) 1 ☐ Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	nination and/	or investigation, in my c	pinion, death occurr	ed at the time, d	ate and place, ar	nd due to th	ne cause(s)			
	With Com	Σ	29b. Signature and title of certifier	~ ms		29c. Licenson	3 804	29	9d. Date signed	(Month, Da	y, Year) L			
_	5		30. Name and address of person who	completed cause of death (I	Item 23a) (T	ype, Print) Crox	roads #	Catri	us V. Dlo	MI	021228			
	Stat		31. Date filed (Month, Day, Year)	32. Polistrar's Si	gnature			, con	VI VICE		-/2-0			
DUM	Registra	ar	APR 2 9 2	2008 Marie	Dr.	Apara								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** THELMA IRENE PRIMM P^{M} 2008 7:20 24, APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE DOVE HOUSE CARROLL WESTMINSTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🔀 F Months Days 578-07-0805 95 Director VIRGINIA 3/17/1913 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner and Examiner a Director HOWARD COLUMBIA 1 ☐ Yes 2X No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5400 VANTAGE POINT RD. 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2★1No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ,o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 2 Specify: WHITE 3 X Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, it all and once. Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM M. MARCUS LUTIE V. MARCUS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCUS L. PRIMM 59 ROCKLAND RD., WESTMINSTER, MD 21158 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) COLESVILLE CEM. 4/29/08 4 ☐ Donation COLESVILLE, MD up ral Service Licensee 22. Name and Address of Facility $\ensuremath{\mathsf{FLETCHER}}$ $\ensuremath{\mathsf{FUNERAL}}$ $\ensuremath{\mathsf{HOME}}$, 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. En of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the representation of the cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforn within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 □ Yes 2 🗖 1 🗆 Yes 2 146 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ MOther (Specify HOSPICE2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 **Physician** Month nsad c 0511 AM tachary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA dical Center timere Ctimere 6. Sex Age (In yrs. last birthday) If Under 24 Hrs Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Year) Days **1** M 2 □ F Director 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director MD1 ☐ es 2 ☐ No timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. College (1-4or 5+) Bethleham 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice osado 19b. Mailing Address (Street and Number or Rural Route Number, City or Fown, State, Zip Code) Baltimore, 20b. Place of Dispo cemetery, crer 20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5 3 ☐Removal from State 5 Other (Specify) 21. Signature of Fureral Service Mense M01401 . Enter the disease, or complications that caused the death. Do not enter the mode of dynck, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending I 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the detached 9□Unknown 9 ☐ Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1∐ Yes 2√ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ² 1 ☐ Yes 1 N Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore MD 21201

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2008 **Physician** 27 APRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALITIMERE BAYVIEW MEDICAL CENTER JOHNS HOPKINS If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 18, 1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Maryland **Funeral** Months Days 1 □ M 2 💢 F 220-03-5687 88 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21224 422 Folcroft Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify: Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Blue Print Dept is 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adeline Kodym Frank Kondziela 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1956 Stanhope Road Dundalk, Maryland 21222 Department of Health an Important: if item 27 is any injury or other trau Angela Burke, Grand-Daughter 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 04/28/08 Metro Crematory Inc. Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Inomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAL ARREST **Physician** /Medical Due to (or as a consequence of): Examiner ARTERY CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, IF FFMALE: 23d. Date of delivery 23c. If ves. outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 2□ No 2 No 1 ☐ Yes 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) SE No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes P 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation nours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2008 APRIL 27

31. Date filed (Month, Day, Year) State Registrar

MAKIA SAID MD. APR 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BALTOMORE, MD 21224

Certificate of Death

2. Date of Death

Month

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4a. Facility Name (If not institution, give street and number) Examiner Hopkins Bayview Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 16/937 Social Security Number **Funeral** Months 1 □ M 2√2 F 224-48-1698 71 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show If Item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at MD Baltimore Middle river Directo 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with t and Mental Hygiene. Is marked other than "natural", or items 23a or 2 7209 Oliver Beach Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 Is marked ot any injury or other traumatic ever Hartsel Feathers Margaret Sharett 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Ryder /husband 7209 Oliver Beach Road Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 4/29/08 Baltimore MD /5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 300 Mace Ave.Balto. MD Funeral Service Licenses 21. Signaturg Wittella Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sclerosis Amyotrophic
Due to or as a confiquence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 dialetes Completed 24a. Was an autopsy Division or Vital 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 2 ☐ Accident 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation thours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

and manner stated.

Physicia-

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Genzals, MD 5605 Hopkins Bayrita Coule

1. Decedent's Name (First, Middle, Last)

Physician

/Medical

9. Birthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry own home 20c. Location - City or Town, State Approximate Interval Between Onset and Death months 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 25, 2008

3. Time of Death

0230 AM

Year

Baltimore

County of Death

25, 2008

State Registrar

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one)

29b. Signature and hitle of certifier

31. Date filed (Month, Day, Year)

APR 29

29c. License number

Balhinor, Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 879 5-2-08 yth and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** AL dna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Geriatric & Rehabillitation MIDDLE iver VyHall | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 25, 1922 If Under 1 Year Birthplace (State or Foreign Country) 5. S214-12-10712 218-09-491 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □X€ 85 Yrs. MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show MD Baltimore Rosedale 1 ☐ Yes 2 🔀 No must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 8 King Henry Circle 21237 USA 'natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner ∏Yes 2 X No fYes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If item 27 is marked other in any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Deaver Marie Deaver ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Rodney / husband 8 King Henry Circle Baltimroe MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/08 Moreland Memorial Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Connelly Funeral Home of Essex 23a. Paid. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumoni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): for use as the burial-Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 2 No 3 Probably 4 √Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No bowe(24a. Was an water autopsy performed? 2 No 1∐ Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mac JULA Registrar's Signature 31. Date filed (Month, Day, Year) State APR 29 Registrar 2008

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:15 P_M **Physician** Ethel Rose Raab 2008 April 24, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 91 215-09-1291 09/09/1916 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD. Baltimore Parkville 1 ☐ Yes 2X No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. I Important: If item 27 is marked other than "natural", or items 23a or in Important: If item 27 is marked other than "natural", or items 23a or in Important: If item 27 is marked other than one in Important in Impor 3110 Garden Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Hall Harry Henry Schissler ပ 2008 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Miller/ Daughter 3110 Garden Ave. Parkville, MD. 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 04/29/08 Parkville, MD. 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cramation Services 8800 Harford Rd. Parkville, MD. 21234 21. Signature of Funeral Service Licensee 11. Enter the disease, or companies that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or he intrailure. List only one cause on each line. m - iate Cause Final se or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ó in the past 12 months?
1☐ Yes 2 🛣 No Month Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ETHEL RAAB Completed by 1 Tyes 2 TNo 3 TProbably 4 TUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2X No 2 X No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State

29b. Signature and title of certifier

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year) APR 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2300 DULANEY VALLEY RD.

Registrar's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 24608

Physician /Medica Examine

Funeral Director

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	5. Social Security Number 218–16–2165		ge (In yrs.	last birthday) Yrs.	If Und Months	er 1 Year s Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov • 6	v. Yea	r)	Cour	place <i>(State or Foreign</i> ntry) 1and	
	Usual Residence of Decedent	<u> </u>											
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Ö	12			Offic	e Ad	minis	trator		Insurance Company				
Be Completed by Funeral Director	17. Father's Name (First, Middle,	, Last)							le, Maiden Surname)				
0	Joseph Kline						Florence						
	19a. Informant's Name/Relations				-		and Number or Ru				te, Zip	o Code)	
	Ann Haney/ Dau	ıghter					el Drive						
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	20b. F	Place of Disponentery, cre Metrop	matory of	ame of r other plac	ce)	Date	20c.	Location - Cit	y or To	own, State	
	4 □ Donation 5 □ Other (Specify)		Crema	tory		:4/24						
	21. Signature of Funeral Service Licensee Crematory 4/24/2008 Alexandr 22. Name and Address of Facility Robert E. Evans Fu												
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Fune 16000 Annapolis Road Bowie, MD 2071 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate	
al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hyperca Due to (or as b. Possib1 Due to (or as c. Orophar Due to (or as	e Asp a conseq a conseq yngea	uence of): piration uence of): a1 Dysp	on	-	Oral Thi	rush					
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	30. Name and address of person					ad I as	ırel, MD	20707					
e	Mythily Vanch	а М. D. /30 r) /32. Regist	rar's Signa	ature 🥒	L KOS	ıu Läl	TIET, III	20/0/					
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DHMH 17 Rev 1/2001

State Registrar

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			Registrar 1. Decedent's Name (Fire	st, Middle, Las	t)			Gililicai	e or bee	4111	2. Date of De			3. Time	of Death	
	Physici /Medio		Justine		Ros	si					April		,2008	1740) M	
	Examir		4a. Facility Name (If not						Town, or Loca	tion of Death		4c.	County of Death	۵.		
	Funeral		Upper Ch 5. Social Security Number			e (In yrs. la	ast birthda	ay) If Unde		nder 24 Hrs.	8. Date of Bi	rth V			e or Foreign	
	Director		218-05-28	73 1	□M 2 KF	87	Yrs.	Months	Days Ho	urs Min.	(Month, Da			nıry) vlan	_	
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€ E	or Atter de Director in by ti	rtific	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of injuding, et	ury - At ho c. <i>(Specif</i>	ome, farm,	, street, facto	ry, office		28f. Location City or To	(Street al own, State	nd Number or Ru le)	ral Route I	lumber,	
20551, 5UStine Division or Vital	To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificate has I een completely filled in by the funeral director, page 2 should	Medical Certification:	29a. Certifier 1	Certifying Ph	ysician: To the best	of my kno	wledge, d	eath occurre	at the time, d	ate and place	, and due to th	e cause(s	s) and manner as	stated.		
SO	n 24 h n 24 h ne Fur	edice		Medical Exar	niner: On the basis o and manner st		tion and/o	or investigation	n, in my opinio	n, death occu	irred at the time	e, date an	nd place, and due	to the cau	se(s)	
CX	To the To the Comp	Ž	29b. Signature and title	of certifier	1			2	c. License nur	mber 50/2		29d. Da	ate signed (Month	n, Day, Yea	(r)	
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	5		30. Name and address	of persyl who	completed cause of d	leath (Iten	n 23a) (Ty 2	pe, Print)	A A	tre.	Be 1 A	17	Md.	210	14	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0422 A M **Physician** Robinson APRIL 25 2008 /Medical 4b - Sity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)

SINCU HOSPITAL OF BALTIMORE Examiner BALTIMOVE CIT If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours Director Usual Besidence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Raltimore MP Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 2☑No Specify: Black Specify: ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer umber Co. Pages 1 and 2 should be filed vent of Health and Mental Hygies int: If Item 27 is marked other it Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KODINGON John Nancy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any Injury or other trau Jarice Bryant-niece Istown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donatien 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 229 23a. In the first of the ship Approximate Interval Between Onset and Death for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. ASC **Physician** /Medical Due to (or as a consequence of): Casclioviscular disease Examiner nerleusine organization in the conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Huperlen tion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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The law requires that the death certificate be executed the attending physician and Division or Vital Records, P.O. Box 68760, signed by to lid be detach certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

death with the Maryland

Maryland 21215-0036

Baltimore,

VATIENT

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

DR. A. AHMED

31. Date filed (Month, Day, Year)

APR 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR AAHMED ND 821 NEWaw 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5+

29c. License number

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE FIRST STATE OF MARY INDEX AND THE STATE OF MARY INDEX.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SHAW **Physician** 26 3:45 2008 A J Pril /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 5. Social Security Number 216-55-7986 Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Days Hours Director Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Raltimore 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 21206 enmore Funeral 12. Was Decedent Ever in U.S. Armed Forces?

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Department of Health and Mental Hygis Important: If item 27 is marked any injury or other #== Be rnes ဂ္ 's Name/Relationship (Type, Print) (Mother la Stantiel Bacon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) md 21206 len more thenue. . Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 1.08 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense Na Baltu. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** hour /Medical Examiner EBRAL EDENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ician and burial-transit ASTROCYTOMA ANAPLASTIC The law requires that the death certificate be executed Due to (or as a consequence of Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year after death.

Director: After this certificate has been signed by the at the kineral director, page 2 should be detached the kineral director, page 2 should be detached to have the fineral director. Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2,1 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Yes 2 🗶 No Other: Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 6 Other (Specify) ၀ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 Natural
2 Accident or Attending Injury 2 🗌 No 1 TYes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 26,2008 2697 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 FRANCIS MUSSAI 31. Date filed (Month, Day, Year) good 32. Registrar's Signature State 2 10 May 1 4 5 10 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Monroe Sandas 1:35PM 04 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist lowson DICO 8. Date of Birth (Month, Day, Year) 05 05 1939 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days 219.26.645 1**X**M 2□ F 68 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be recitied at Dwings Mills Baltimore 1 ☐ Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 Cascade Kun Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XNo Specify. Specify: Back ģ 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland 1 and 2 should be t Health and Mental vank Sanders Midaett Odessa ပ 19a. Informant's Name/Relationship (Type. Print) 67and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health an Important: If item 27 is any Injury or other trau Cascade Run Court Owings Mills MD 21117 Daughter Baltimore, 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 XBurial 2 ☐ Cremation 3 Removal from State 05 02 08 Park Cemetery Windsor Mill, MIP 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funtral SICS Rundalistonin MD 21133 8728 Liberty Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Montus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be execute burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes Mo 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS DI & 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending n 24 hours after death.

he Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Sr Tanson mo zray 31. Date filed (Month, Day, Year) APR 29 MI) 32 Registrar's Signature State Registrar

WILLIAM SNOWDEN

		-	For State of Ma	aryland		ertment of H Stificate of L		nd Mental Hy	/giene Reg. No.	2008	13886
			Decedent's Name (First, Middle, Last)					2. Date of De	eath	Voor	3. Time of Death
	Physicia		William M. Snowden					April	28,	2008°	3:00 A ^M
a margin	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or		Death	4c. C	ounty of Death	
*			Stella Maris Hospice			Luterv				Baltim	
f	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1	e <i>(In yr</i> s. <i>Ia</i> s 7 9	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bi (Month Dec 3)	rth 1928	9. Birthr Cour On	place (State or Foreign htry) LO
	ס		Usual Residence of Decedent								Od India City Linia
	urylan show	_	10a. State 10b. County	10c. City,	Town or Lo						0d. Inside City Limits 1 □Yes 2 🛣 No
	8a-f	Sct	Maryland Howard		COL	umbia 10f. Zip Code			10g Citize	en of What Cour	
	a or 2	Funeral Director	8610 Snowden River Parkway	Ant /	25	21045				JSA	
	ns 23	era				Was Decedent of Hi	spanic Orig	in? (Specify Yes or N		4. Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the "Medical Eventine must be neitlied at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Armed Forces? 14 ☑ Yes 2 □ □ If Yes, Give Year or Dates:	№ 195 195	2 '	f Yes, specify Cuba 1 □Yes 2ሺ No	n, Mexican, Specify:	Puerto Rican, etc.)		Black, White, Specify: Whi	
9	2 hou	Completed by	15. Decedent's Education		16a. Dece	dent's Usual Occupa	ation	of working	16b. Kin	d of Business/In	dustry
218	thin 7 le. lan "n	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	5+)	`life. I	bo Not use retired Salesman)	or working	۸,,,	comobile	
2	ed wi ygien ver th t, th	ပ်				alesman	40. Mathe	's Name (First, Middle	1		<u> </u>
and	be fill	Be	17. Father's Name (First, Middle, Last) Vernon L. Snowden					rtle Mini		umame)	
Σ̈́	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type. Print)		19h Mailir	ng Address (Street :		r or Rural Route Num		Town, State, Zir	Code)
Ma	id 2 si Ith an 27 is i							ne Boyce,			
ē,	s 1 an f Hea item 2	1	Constance Bourne, Sister 20a. Method of Disposition			sition (Name of natory or other plac		Date		ation - City or To	
E O	Pages Tent o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			ematory In)4/28/08	Balti	imore, N	Maryland
Baltimore,	permit. Departn Importa any Inju		21. Signature Tuneral Service Logasee Thomas Gregor	ety Of Mar Road Balti	yland, more,	Inc. Marylar	nd 21228				
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	Physician	6 Ti	Immediate Cause (Final disease or condition		er						Onset and Death
al-	/Medical		resulting in death) Due to (or as								
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260	e be (dical E	d.			_					
9	tificat ig phy as the	ledi									-
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth			☐ Ectopic pregnanc	y		2	3d. Date of deliv	very Day Year
	requires that the death certifineen signed by the attending I nould be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown	at time of dea	ath 5[Other (specify) _				Workin	52,
P.O.	res that the de signed by the s be detached f		Part II. Other significant conditions contributing to death b	out not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	I tobacco us	se contribute to t	the cause of death?
ds,	uires r sign id be	d by						1□	Yes 2]No 3□ Pro	bably 4 🔣 Unknown
O O	w requis s been s should	Completed						24a. Wa		24b. Were aut	opsy findings available
æ	: The law cate has b page 2 st							—— aut per 1 □ Yes	opsy formed? 2X No	prior to co death? 1 ∐Yes	mpletion of cause of
ta	ician: The certificate ector, pag	BeC	25. Was case referred to medical				26. Place	of Death (Check only		10100	2 (3.10)
+	nysici nis ce direc	일	examiner? 1 ☐ Yes 2 K No Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatie	nt 3 □ DOA Oth	er: 4□Nu	rsing Home 5 🗆 Re	sidence 6	X Other (Spec	(fy) HOSPICE
0 0	ng Pl	ë	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Inju		28b. Time o Injury	Wor	k?	28d. Describe	e how injury	occurred	
sio	tendi eath. tor: A the fu	cati	2 Accident investigation				Yes 2 □		(04 4		and Davida Muselhan
Division of Vital Records,	al or At after d I Direct d in by	Certification:	determined 286. Place of In	jury - At hom tc. <i>(Sp</i> ec <i>ify)</i>	ne, tarm, st	reet, factory, office		City or T	(Street and own, State)	i Number or Hui	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner st	of examination	ledge, dea on and/or in	th occurred at the tinvestigation, in my o	me, date ar opinion, dea	nd place, and due to the the time	ne cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	2.1	4	29c. Licens	e number	740	29d Date	e signed (Month	Day, Year)
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	1701		DR. ERNESTINE WRIGHT 230			Print) VALLEY RD.	, TTM	ONIUM, MD	21093	3	
	Sta		31. Date filed (Month, Day, Year) 32. Poist	rar's Signatu	ire	24 202					
Registrar APR 2 9 2008 Strawn It Speaks											

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Mildred Jean Sitar

			1 _ State		partment of H e <i>rtificate of L</i>			giene Reg. No. 2	08 13887
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physicia /Medic		Mildred Jean Sita	r			Month April		^{Year} 008 4:45 a ^M
and.	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	_	4c. County of	f Death
.~			Future Care Irvington 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	Balt :	imore If Under 24 Hrs.	8 Date of Bir		A 9. Birthplace (State or Foreign
	Funeral Director		219-40-6812	69 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da MAR 1	1939	Pennsylvania
	ס		Usual Residence of Decedent						
	arylar show	or	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits 1 X Yes 2 ☐ No
	the M	Director	MD N/A 10e. Street and Number	Baltim	ore			10g. Citizen of W	hat Country?
	3a or		400 S. Oldham Street		2122	.4		US	SA
	ems 2	Funeral	11. Marital Status 12. Was Decedent 8 Armed Forces?	ver in U.S.	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race Black	- American Indian, , White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it is Mysilen Exp. in crimit to criffic deat.	by Fu	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2X N	10	1 □Yes 2 XNo	Specify:		Specify:	White
9	thour	ed k	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. De	cedent's Usual Occup	ation		16b. Kind of Bus	
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and	l be fil ed oth ed oth	Be	17. Father's Name (First, Middle, Last) Walter F. Buckingham			Mildre		Maiden Surname	
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ž	and 2 lealth a m 27 is her trai		Mildred T. Sitar - daughte	r 400	S. Oldham	Street,	Baltimo	ore, MD	21224
ore	Pages 1 ann pent of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State		position (Name of rematory or other place		Date		City or Town, State
Baltimore, Maryland 21215-0036			4 ☐ Donation 5 ☐ Other (Specify)	1	rematory,			Baltimo	
Bal	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee H. Will	iams	Cremation 299 Frede	s Society rick Road	of Mary d, Balt	yland, Ir imore, MI	nc. 21228
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not e	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
and the	Physician		Immediate Cause (Final disease or condition resulting in death)	VCED P	ARKINS	C 2 KO	DISEAS	E	Syears
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68760,4	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Ex	resulting in death) Last Due to (or as	a consequence of):					
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<u>о</u> .	hat the	Phy	9 Unknown Part II. Other significant conditions contributing to death be	it not resulting in the	underlying cause giv	en in Part I	23e. Did	tobacco use contri	bute to the cause of death?
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/ita	cian: ertifica	Be C	25. Was case referred to medical examiner?	121011	, JV	26. Place of Dea	th (Check only		
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	To the within To the comple	Me	29b. Signature and title of certifier	- 487	29c. Licens				(Month, Day, Year)
			* Kanal K. Zang	w.	DO	0 1836	2	4-2	16-2008
) .		30. Name and address of person who completed cause of d		pe, Print)	to 1 in	Ba11	int Gro	Md21229
	V - C'	to	Komal K. Dang M. D. 3455	Wilkens ar's Signature	the su	W -10 '	DUCT	incore,	144427
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month PM **Physician** 21:10 23 2008 Horil Linwood "/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner medical altimore Cente MD 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 7-1-1956 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1₩ 2□F Yrs. MD 216-66-8543 51 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State a or 28a-f show t be notified at 1 □Yes 2□No Abingdon Director MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U S 21009 Α 3405 Henry Harford Drive 'natural", or Items 23a **Examiner must** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Specify:Black 1 ☐ Yes XXNo Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene.

Is marked other than Flementary/Secondary (0-12) Computer Instructor 12th grade 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Pearl Irene Washington William Settle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3405 Henry Harford Drive Abingdon, MD 21009 Angela Eve Settle-Wife item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4-30-2008 Timonium, MD Valley Dulaney 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee MD 21202 Avenue Baltimore, 1101 E. North 23a. Part1. Enter the disease, or complications than aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Von-sma **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for the a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate has rector, page 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2X No 1 📈 Inpatient ို After this of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation within 24 hours after com...

To the Funeral Director: Aft 1 Yes 2 🗆 No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of

31. Date filed (Month, Day,

(Month, Day, Year) APR 2 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

301 St. Paw

32. Registrar's Signature

29c. License number

Baltimore,

21202

3008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend sitem 20b per the 8879 5-6-08 vt. State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26, 2008 Year **Physician** April 8:00 A. William P. Skopp /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Baltimore County Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 01, 1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🗗 M 2 🗆 F Marylánd 218-14-0452 84 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Exemplest must be notified at 1 ☐ Yes 2 No Baltimore County Maryland Towson Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Smeton Place 21204 Unit 505 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 █No Saltimore, Maryland 21215-0036 Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Skopinski Antoinette Wojciekowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) Mrs. Gertrude(nee Zalowski)Skopp 1 Smeton Place unit 505 Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem.Gar. 2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service Licensee Approximate 23a. Par 1. Either the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final seas **Physician** Schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of) Exami and burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) William 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. I Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie AMIL 26 2008 who completed cause of death (Item 23a) (Type, Print)

WE MY 6701 N. CHARLES ST POHXIN MO ZIZOY

DHMH 17 Rev 1/2001

Registrar

24

31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 Vin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Months 218-46-8 1⊠M 2□ F Director 94 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at 1 Ø Yes 2 □ No Director MD Itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a 3612 Venue 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 M2Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☑ No ģ Specify 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Item Maonce. Elementary/Secondary (0-12) College (1-4or 5+) 12 Dethlehem Ilwright 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be meiser -illian izabeth ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21206 altimore Johnesser 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 5-2-2008 4 ☐ Donation 5 ☐ Other (Specify) iemetery hapel + Cremation Services-Parkville ad Parkville mo 21234 Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Char 8800 Harford Road Approximate Interval Betwee Orset and De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 2 🗌 No 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 □No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ZINO 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated... 29b. Signature and title of 29d. Date signed (Month, Day, 31. Date filed (Month, Da 32. Registrar's Signature State 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

08-02978 Tavon Smith	1. F	Please Type or Print in Black Indel State of Maryland / Departm State Certific	ient c	nk. Ensur of Health ar of Death	r e All Copi nd Mental F	es Are lygiene	Legib Reg. N			8 389				
	D					2. Date of	Dav	, Ye		ime of Death				
Physician/ Mer 'Examiner		Tavon F. Smith				April	16, 2008	4c. County		10201113				
;	4a.	acility Name (if not institution, give street and number)		4b. City, Town, o	or Location of Dea	tn			n/A					
	ľ	Sinai Hospital	idhdov/	If Under 1 Ye	ear If Under 24H	rs. 8. Date	e of Birth(M	M/DD/YYY	Y) 9. Birthpla	ace (State or				
Funeral	5. 8	cial Security Number 6. Sex 7. Age (In yrs. last bi		Months Da		^{in.} Jan	1 1	198	1 Foreign	wlnad				
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21.2 rtal F	w Keith F. Sillitin							er, City or	Fown, State, Z	ip Code)				
should and Me is ma attice.	19a. Informant's Name/Relationship (Type, Print) Charlotte Garner/ Mother 19b. Mailing Address (Street and Number of Rula 3028 Glenmore Avenu							cimo	re, mo	1 2 1 2 1 4				
MC santh a cm 27 raum	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,							20c. Locati	on - City or To	own, State				
Ore ge 1 a of He If it	1	Burial 2 Cremation 3 Removal from State	te crematory or other place) Woodlawn Cemetery 4/					loodl	awn,M	aryland				
Baltimore, MD permit Pages I and 2 sho Departie and 2 sho Departies and 2 sho minortant: If item 27 is injury or other traumati	4	Donation 5 Other Specify; Signature of Funeral Service Licensee	-1.	O Maria and Ade	troop of Encility C	hatm	an-H	arri	s Fun	eral Home				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exevithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial-	Physician/Medic	FEMALE: 23c. If yes, outcome of pregna	ancy		3 Ectopic p	reonancy		23d. Da Moi	ate of delivery	oay Year				
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To the within 2 To the complete	Med	and manner stated.			License number			29d. Da	te signed (M 17, 2008	onth, Day, Year)				
		Carolitaller			O.C.M.E.			April	17, 2000					
\		30. Name and address of person who completed cause of death (Item	1 23a)	Conn Stroot 5	Baltimore, MD	21201								
,		Carol Allan, MD Assistant Medical Examiner		em Sueet, E										
Si Regis	tate	31. Date filed (Month, Day, Year) APR 2 9 2008	Year 2008 Registrar's Signature											
Regis	للنجيد		6											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Reg. No. 2008 389								
Physician		an	1. Decedent's Name (First, Middle, Last)			Day Year 12 3. Time of Death		
		/Medical Maria Secada, M.D.			April	27 2008 12:15 A M		
	Examin	er	Summit Park Nursing Home Catonsville			Baltimore		
I	Funeral Director		5. Social Security Number 267-78-0018 6. Sex 1 M 3 F 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 F Months Days Hours M	in. (Month, Da	h y, Year) 9. Birthplace (State or Foreign Country) 7 1916 Cuba		
7	put M		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town	or Location		10d, Inside City Limits		
	Maryla f sho	jō		Cimonium		1 ☐ Yes 2 ▼No		
	r 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?		
36	er death with the Marylan items 23a or 28a-f show	ralD	2206 Westridge Rd.	21093		USA		
	hours after death with the Maryland tural", or items 23a or 28a-f show all Foat. incr or unit be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 No Specify:		Specify:		
			15. Decedent's Education 16a. I	Decedent's Usual Occupation	Cuban	Hispanic 16b. Kind of Business/Industry		
215	within 72 iene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of v life. DO NOT use retired)	vorking			
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	and 2 ealth a m 27 is ner tra	١.,		2206 Westridge Rd.	-			
Baltimore,	nit. Pages 1 and artment of Healt ortant: If item 2 injury or other		4 Donation 5 Other (Specify) Immacu	Disposition (Name of crematory or other place) Late Conception Ce	5/1/08 metery	20c. Location - City or Town, State Towson, MD		
Ва	permit Depar Impor any in		Joseph Kellner	22. Name and Address of Facility Lemmon Funeral Ho 10 W. Padonia Rd	me of Du ., Tinmon	laney Valley, Inc.		
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			rrest, Approximate Interval Between		
F	Physician /Medical	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Conset and Death 5 yrs					
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	To COLL	Σ	29b. Signature and title of certifier	29c. License number	69	29d. Date signed (Month, Day, Year)		
	10	30. Name and address of person who completed cause of death (tem 23a) (Type, Print) word from D. Blunger w 5/bv. Kolling M Buth hd						
	Sta Registra							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician º/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 78.12 MOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 F 214-18-Oct 16, 1921 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Himore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 302 21207 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 € Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore College (1-4or 5+) Elementary/Secondary (0-12) ross/Ng GUARD 6 th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GICAMINA ဂ္ DAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515ter MAR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -3-08 to Jesus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Joseph N. Zannino Jr. Conkling St. Baltimore, MD 21224 23a. Part1. Enter the disease shock, or heart failure or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or all a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ¥ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of pure in who completed cause of death (Item 23a) (Type, Print) 501 7035)21-1 31. Date filed (Month, Day, Year) 32: Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

APR 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 2 008 A PRIL SELLMAN TIA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Days Months June 13 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 YNO Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21226 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) School Elementary/Secondary (0-12) river 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SELLMAN LIFFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Point SISTER ct. Curlis Bay, mD. 21226 lonya 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4-26-08 hindalk MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 270 FredHILTON Pass P. march fitti 23a. Part 1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) multifocal leukoencephalopati Progressive 2 months Due to (or as a consequence of): Acquired Immunodeficiency Syndrome AIDS Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Human Immunodeficiency ears Due to (or as a consequence of) F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant 2 Fetal death 1 Live birth 3 🗌 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 Tes

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division

or Attending

the Hospital

Physician

/Medical

Director

Funeral

<u>م</u>

Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner

dical 25

burial-transit and attending physician the ō the ģ within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should I Be ၉ Certification:

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cian/Me	iF 2
Physi	P
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mplete	
U	

24a. Was an 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tes

5. Was case referred to medical examiner? 1 Yes 2 No	Но
7 Manner of Death	

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 🗌 Yes 2 🗌 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \sum Nursing Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

(check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

1. Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

Medical

29c. License number . Res-000

Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 22,2008

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Durand Christine

600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year)
APR 2 9

2. Registrar's Signature

DEALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of Registrar Ceres	artment of Health and M rtificate of Death	lental Hygier	2008 13893	
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death	
	/Medic	al	Elna Selena Smith		April 25,	2008 12:10 pm ^M	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-	Europal		Riverview Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	ESSEX If Under 1 Year If Under 24 Hrs.		Baltimore 9. Birthplace (State or Foreign	
ı	Funeral Director		212–05–8851 ^{1□ M 2} ♥F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 03/08/192	20 Country) Maryland	
	p		Usual Residence of Decedent				
	anylau show	-	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	he M	ectc	Maryland Baltimore Middle R		10-		
	with t	D		10f. Zip Code		Citizen of What Country?	
	heath	Funeral Director	1320 Windlass Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21220 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examiner must be notified at	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 📉 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ X No Specify:	Rican, etc.)	Black, White, etc. Specify: White	
20	72 ho	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	16b.	Kind of Business/Industry	
21	within 7 ene. than r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,,,g		
21	e filed w al Hygier other th	Cor	4 Homen			wn Home	
and	ould be fi Mental H tarked oft	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Maryland	2 should be and Mental Is marked a	၀	Charles Connolly 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	Elna Jung Address (Street and Number or Run		derman	
Ma	nd 2 salth an 27 is rrau					Maryland 21901	
re,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dispo		Date 20c.	Location - City or Town, State	
E	Page ient o nt: If ry or		1 XBuriai 2 Cremation 3 Memoval from State	l Memorial Gardens	4/29 Mi	ddle River, Maryland	
Baltimore,	permit. Pages 1 and Department of Healti Important: If item 2? any injury or other in		HOLLY III	2. Name and Address of Facility Cruzdzinski Funera		date revery rary tand	
0	88 = 8		Richal C. Tally 5- 1	407 Old Eastern A	venue Ess	ex, Maryland 21221	
	Physician		Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition.)	er the mode of dying, such as cardiac	· · ·	Approximate Interval Between Onset and Death Www.Khawm	
П	/Medical		resulting in death) Due to (or as a consequence of):				
ı,	Examiner		Sequentially list conditions, b.				
∇	ed isit	Examiner	if any, leading to immediate Due to (or as a consequence of):				
	ate be executed obysician and the burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	sician buris	Ical E					
9	ificate g phys as the		0.				
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific; within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pi completely filled in by the funeral director, page 2 should be detached for use as t	ed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
T			Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?	
rds			Hypothyodas, AS	CVD	1 🗆 Yes	2 No 3 Probably 4 Onknown	
of Vital Records,		Completed	HTN.		24a. Was an	24b. Were autopsy findings available	
Ä		Com			autopsy performed		
/ita		Be (25. Was case referred to medical examiner?	26. Place of Deat	n (Check only one)		
7 <	Physic this co	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			6 ☐Other (Specify)	
n	ing P	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
isio	Itend death tor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	286 Logation (Street	and Number or Rural Route Number,	
Division	after after Direction by	Certification:	4 Homicide determined determined determined	eet, ractory, onice	City or Town, St	are)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause ed at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)	
	To the within Fo the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
			► NHS N-D	D-38754		4-26-2008.	
1	3			ASTERN BLUD	, M.D) - 21221.	
	Sta		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature				
Dri	Registr MH 17 Rev 1/20	ė,	APR 2 9 2008	ask.			
201	1711 I / NEV 1/20	/VI					

ORIGINAL

08-03162 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Norman Stamp State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0130 hrs Medical Examiner April 24, 2008 Norman Stamp 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University Hospital **Baltimore** If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours oreign Months Director Country) Maryland 219-42-2248 1 X M 2 F 02/05/1943 65 Vrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show Maryland Baltimore Essex death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Waterview Way items 23a or 21221 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married Yes 2 X No 00 within 72 hours after If Yes, Give Year Yes 2 X No specify: White 3 Widowed 4 Divorced Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injury or other transmatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Balto. City Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Stamp Myrtle Scoten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Stamp (Wife) 1305 Waterview Way, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. Baltimore, Maryland 04/28/2008 4 Donation 5 Other Specify 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Pineral Service Licensee 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fature. List only one cause on each line /Medical a Multiple Gunshot Wounds Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed and Physician/Medical UNPENDED AMENDED the attending physician led for use as the burial certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown g Unknown signed by the be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 ✓ No 3 Probably 4 Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Apr 24, 2008 Subject shot by Police 0025 hrs Natural Yes 2 V No Director: d in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 400 North Haven Street, Baltimore, Md. determined (Specify) Bar/tavern 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical

State

29b. Signature and title of certifier

David Fowler M.D.

31. Date filed (Month, Day, APR 2

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 24, 2008

Registrar's Sign

and manner stated

Chief Medical Examiner

12

OCME

30. Name and address of person who completed cause of death (Item 23a)

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Amend Item tate of Maryland, 0872876816 Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 008 BARBARA Month Physician 7:00 AM APRL 26 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10393 TUSCANY ROAD HOWARD ELLICOTT CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 0373171938 577-52-3497 70 Director MINNESOTA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Items 23a or 28e-f show traumatic avent, the Medical Examinat must be codified at MD 1 Yes 2 No Funeral Director HOWARD ELLICOTT CITY 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10393 USA TUSCANY ROAD 210 47 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ð Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARS SOCIAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pernit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked o any njury or other traumation. WILLIAM BLAKE PERMELIA LITSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TUSCAN' RODD, ELLICOTT CITY, MB 21042 JULIE ANN "TASSA / DAUGHTER 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) ARDENT CREMATORY APRILOGOOD HANDVER. MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 4 DE CHISPULLAN JO YELLENNOS CECE COTRANSOS THEOLOGA 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** He polo ren Willen disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner whose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 200 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2.40 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident Injury 5 Pending investigation M 1 Yes 2 No Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hin 24 hours a in Fritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of eartifier 29d. Date signed (Month, Day, Year) 29c. License number 2 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUNTH A. KNOCE SuitE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03129 State of Maryland / Department of Health and Mental Hygiene Zy Key Taylor Certificate of Death 1. For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1904 hrs April 22, 2008 Medical Examiner 4c. County of Death Town, or Location of Death 4b. Qfty, 4a. Facility Name (if not institution, give street and number **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday 5. Social Security Number MI) **Funeral** Foreign -81-1205 Months Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State BA/4imore Yes 2 No yes, the month of the state of the state of the state of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f shower traumatic event, the Medical Examiner must be notified at once, when traumatic event, the Medical Examiner must be notified at once. **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2/206 GLen 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes BIACK Specify: Yes 2 X No specify: Yes, Give Year Divorced imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after Widowed Δ ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) infant infant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rubinson KRYa SEAN Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) - rulother KickeyA Robinson Pembroke Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a, Method of Disposition crematory or other place) Removal from State Burial 2 Cremation 3 22. Name and Address of Facility Donation 5 Other Specify 21. Signat e of Funeral Service Lic. BAI L'MUTES m() 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Death /Medical Sudden infant death syndrome Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed e attending physician and for use as the burial - tran Physician/Medical 6,8,16a-b,perFF ,perME,q880 6/19 6/19/08 TT X XUNPENDED 23d. Date of delivery Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? certificate has been signed by the ector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown Ś Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed′ ✓ Yes 2 death? 1 🗸 Yes 26.Place of Death (Check only one) this certifical director, 25. Was case referred to medical Division of Vital Be Other; Nursing Home 5 Residence 6 Other: examiner? Inpatient 2 PER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 23, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1PR 29 Registrar

OCME 2006

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2:54PM Turner 2002 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9008 Baltimore larpleys Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1**X**M 2□ F Days 212.42.7826 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item 223a or 28a-f show amy injury or other traumatic event, the Medical Evant actional and proce. 28a-f show Baltimore Ba Himore MD 1 ☐ Yes 2 XNo Be Completed by Funeral Director 10e Street and Number 10g. Citizen of What Country? 4008 21237 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 21 No Black Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry
Whited States 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Project Coast Guard 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Elexander ပ 19a. Informant's Name/Relationship (Type. Prio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Circle Baltimore MD 21237 9008 20b. Place of Disposition (Name of cemetery, crematory or other place) ara Turner 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/29/08 Owings MILLS, MD Garrison 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral SVCS 8728 Liberry Road Randallotown MD 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, furth as cardiac or respiratory arrest, shock, or he kt falure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pancreatic Cance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy 2 🕒 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) BOOK - H6-40 D66040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard Schraedel, M.O. 7501 Osler Drive 10 wson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1 **Physician** 2008 2115 pM Charles Edward Tegges /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Belair | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 30, 1931 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 76 MD 220-30-6138 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Middle River Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21220 1300 Burke Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 **M**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial Artist Advertising yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rapheal Perouty Clifford Tegges 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1312 Burke Road Baltimore MD 21220 Diana Bongiorno /daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or of
once, Holly Hill Cemetery 4/25/08 Baltimore 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pureral Dervice Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or shock, or heart failure. List only cations that caused the e cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician umonia disease or condition resulting in death) /Medical Due to [or as a consequence of) Stage Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident

Diwision or/Vital Records, P.O. Box 68/60 certificate within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

ms 23a or 28a-f show must be notified at

Certification: To

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a, Certifier

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

30. Name and address of person o completed cause of death (Item 23a) (Type, Print)

per Chesapeake Drive Zamora mo s GIRCO 31. Date filed (Month, Day, APR 2 9 2008

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Mar	yland / I	Depa <i>Cei</i>	artme <i>tifica</i>	nt of H te of L	lealth a	and M	ental Hy	giene Reg. No.	8008	13901
	Physici /Medio		1, Decement's Name (First, Middle	le, Last)	320	en	ce			-		2. Date of De Month	eath Apr ⁰ 21	, 2008 ^{'ear}	3. Time of Death 11:15 a
	Examir		4a. Facility Name (If not institutio	n, give street and Blue Point N	number) Iursing H	lome		4b. City	, Town, or	Location	of Death Baltin	nore	4c.	County of Deat	WA.
	Funeral Director		5. Social Security Number 213-30-2215	6. Sex 10 M 2	7. Age (In yrs. last bi	thday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth 26 , 793	9. Birth	place (State or Foreign 16:Carolina
	Maryland s-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	1	IOc. City, Tow	m or Lo	cation	В	altimore)				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n with the 3s or 28	al Direc	10e. Street and Number 3804 Fairview Aven	nue				10f. Z	p Code	212	16		10g. Citi:	zen of What Cou U.S	untry? .A.
920	iges 1 and 2 should be liled within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f ehow or other traumatic event, the Medical Examinar most be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 🔲 Ye	Decedent Ev d Forces? es 2 No . Give or Dates:	er in U.S.	l l	Was Deci f Yes, sp I ☐ Yes		spanic Ori n, Mexicar Specify:		city Yes or No Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
1215-0036	within 72 ho ine. ihen "natur e Medical	mpleted	15. Deceder (Specify only higher Elementary/Secondary (0-12)		<i>ed)</i> ge (1-4or 5+)		Deced (Give life. I	lent's Us kind of w DO NOT	ual Occupa ork done d use retired LII	ation furing mos neman	t of workir	ng	16b. Kir	nd of Business/I Rail	ndustry road
and z	d be filed v antal Hygie ced other t c event, th	Be	17. Father's Name (First, Middle,	Last) nuel Torrend	ce		-				er's Name	(First, Middle	, Maiden :velyn	Sumame) Hardy	
ary	and 2 should be lealth and Mental in 27 is marked her traumatic ev	To	19a. Informant's Name/Relations Thelma Wright Sist	ship <i>(Type, Print)</i> ter		198	. Mailin	g Addres 804 F	s (Street a	and Numbe Avenue	er or Ryra Baltim	Route Numb ore, Mary	per. City of land 2	Town State, Z 1216	ip Code)
saitimore,	permit. Pages 1 and 2 Department of Health 6 Importent: if Item 27 II any Injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S		om State	20b. Place o cemete	ry, cren We	estern	other plac Cemete			ate 04/26/08		cation - City or 1 Baltimo	
Dail	Dennit. Depart Import any inj		21. Signature of Funeral Service	Licensee	E,	-,0	22	. Name	ste B	rothers utaw Pl	Funer ace Ba	al Service Itimore, M	P. A.	17	
	Physician /Medical		23a. Fart 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause of	on each line.	se death. D	A	er the mo	de of dyin			r respiratory a			Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due	to (or as a	consequence	of):								
0,0070	icate be executed physicien and s the burial-transit	dical Exan	that initiated events resulting in death) Last	c	to (or as a	consequence	of):								
O. Box od	ath certif ittending or use a	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Liv 4 ☐ Pr	outcome of ve birth 2 regnant at tin	Fetal death		Ectopic (oregnancy pecify)				2	23d. Date of deliver Month	very Day Year
ords, P.	w requires that the de been signed by the a should be detached (۵	Part II. Other significant conditi	ons contributing t	to death but i	not resulting i	n the ur	nderlying	cause give	en in Part I			tobacco u Yes 2		the cause of death?
בים	The ste h	Completed										24a. Was auto perfo		24b. Were aut prior to c death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
2	artific ctor.	Be	25. Was case referred to medica examiner?							26. Place	of Death	(Check only	one)		
5	\$ 5 E	on: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Da	Inpatient	28b.	Time of		OA Othe 28c. Injury Work	4 DE NU		ne 5 🗌 Resi 8d. Describe		Other (Spec	ufy)
200	if or Attending P efter death. Director: After t in by the funera	ertification	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be	Month, Day Y	- At home, fa	njury	М	1 🗆 '	(? Yes 2 ☐		8f. Location ((Street -	d Number == 5	ml Pouts Alimet
2	for A efter Direct	ertil	4 Homicide determ	nined 200. Pi	uilding, etc. ((Specify)	, S(F6	et, iacio	y, onice		4	City or To	wn, State)) }	ral Route Number,

Medical C

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEIGHTS
32. Pelistrar's Signature

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 922 M MARGARET ROBINSON WARDWELL A-PRIL 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Good Samaritan Hospital None | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 13,1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M X X F Yrs. 91 Maryland 218-50-8554 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County XXX es 2□No Maryland Baltimore None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Winston Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZATNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifton Robinson Wardwell Margaret Winston Brundige 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winston T Brundige Cousin 312 Brightwood Club Drive Lutherville Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XX Burial 2 □ Cremation 3 Removal from State St Johns Cem Huntingdon May 1,2008 | Baltimore, Maryland ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the dise v.e., or complication shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 26 N untenoun disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 117 Yes 2 No 27. Manner of Death Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 26, 2008 000 18230 Sc - D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATHIC SHASHICHARAN, GOOD SANARITAN HOSPITAL, MD 21239

d (Month, Day, Year)

APR 2 9 2008

RESIDENT Signature

APR 2 9 2008

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) APR 2 9 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	Otate of Marylan		tificate of		R	eg. No. 2008	13903
Physic /Med		Decedent's Name (First, Middle, La	Mildred W	ashing				pr 20, 2008 Year	3. Time of Death 0415
Exami		4a. Facility Name (If not institution, giv Genesis Healtl	e street and number) ncare - Hammonds La	ne Center		r Location of Death Balti	more	4c. County of Deat	h N/A
Funeral Director		5. Social Security Number 6. S 219-14-4038	Sex 7. Age (In yrs. 1 ☐ M 2 ☑ F 10	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul 10,	Year) Co	hplace (State or Foreigr untry) Maryland
e Maryland la-f show tified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland	N/A	y, Town or Loc		Baltimore			10d. Inside City Limits 1 X Yes 2 No
th with th 23a or 28 ust be no	al Director	10e. Street and Number 2711 Bookert Drive			10f. Zip Code	21225	1	Og. Citizen of What Co U.S	-
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2☐No If Yes, Give Year or Dates:	/as Decedent of H Yes, specify Cub ☐ Yes 2☐ \ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify:		
ING Z1Z13-UU36 be filed within 72 hours af ntal Hygiene. d other than "natural", or event, the Medical Exami	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+)	16a. Decede (Give k life. D		oation during most of word d) estic Cook	king	16b. Kind of Business/ Johns Hop	Industry kins Hospital
YIBNG Z	ā	12 17. Father's Name (<i>First, Middle, Las</i> Arthur) Johnson			18. Mother's Nam		Maiden Surname) ria Johnson	
Marylar nd 2 should by lith and Mente 27 is marked r traumatic er	ř	19a. Informant's Name/Relationship Regina Rogers	(Type. Print)	,	,	and Number or Ru oz #29 Rome		r, City or Town, State, 2	Zip Code)
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 Deurial 2 Cremation 3 I 4 Donation 5 Dother (Special Signature of Europa Service Light)	fy)	Mt. Pleas	ition (Name of latory or other pla ant United N Name and Addre	/lethodist	04/26/08	20c. Location - City or Mary	Town, State yland
Depriment of the control of the cont		Juan Al	100 F.		Estep 1 1300 E	Brothers Func utaw Place E			Approximate Interval Between
Physician /Medical Examiner ag physician and as the purial-transit		23a. Part I. Enter the disease, or cor shock, or heart failure. List only immediate bause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq C. Due to (or as a conseq d.	uence of):	Inder Irter	CHON	ROK		Onset and Death
death cer death cer e attendir d for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	aldeath 3 🗆	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	livery Day Year
Hecords, P.O. The law requires that the tee has been signed by the teep agge 2 should be detached.	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	
	Completed						24a. Was a autop: perfor 1∐ Yes	sy prior to med? death?	utopsy findings available completion of cause of cause of
	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Oth	nor:	th <i>(Check only or</i> ome 5 ☐ Resid	ne) lence 6 □Other (Spe	ecify)
ath. rr: Afte	ation: T	27. Manner of Death ↑ Natural 5 Pending ∠ Accident investigation		28b. Time of Injury	28c. Inju Wo M 1	nyat rk?]Yes 2∐No	28d. Describe h	ow injury occurred	-
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
To the Hospital or Aviithin 24 hours affer of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying P medical Example 1	hysician: To the best of my kno iminer: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	e, and due to the durred at the time, d	cause(s) and manner at date and place, and du	s stated. e to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier		~	29c. Licens		1	29d. Date signed (Moni	th, Day, Year)
1		30. Name and a viress of person who			Print)	05346	ad ci	len Burn	51061 08
	tate trar	31. Date filed (Month, Day, Year) APR 2 9	32. Registrar's Signa		2 82	20 12	.,	141.00.14	1-11-0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Elnora Bell Wilson 23 2008 April 1:15 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Gilchrist Baltimore Towson 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Days Min. 1 □ M 2 X F Months Hours 325- 28-3782 Director January 5, 1924 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f short must be notified Be Completed by Funeral Director Maryland Baltimore Baltimore 1 ☐ Yes 2K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1321 Evering Avenue 21237 United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2X☐ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home and Mental Hygier is marked other th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Harry Α. Marsteller Laura В. Green other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2140 Herbert Ave. Westminster, MD 21157 Ronald Wilson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Mausoleum April 25, 2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers FuneralDirectors, Inc. 21. Signature of Funeral Service Licensee MOOJJ 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Pa 11. Enter to dise to or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Ancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dure to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding hours and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 620 N. Chiles St. Balto Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 66

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

mc 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daniel Leroy Wild		1- For State	State	e of Maryla			ment of <i>ficate of</i>			Mental	Hyg		Reg. No.	. 21	00	8	390
Physicia	n/	1. Decedent's Nam			_							Date of Dea	ath Day	Year		3. Time of 1655 I	
Medical Examir	ner	Daniel 4a. Facility Name (Leroy Wi					b. City. T	own, or Lo	ocation of D		April 18,		. County of	Death	10001	iis
Ì			rson Avenue					Hano					F	loward			
Funeral Director		5. Social Security 1 216-60-	5470	Sex	7. Age (In		birthday)	If Unde		If Under 2	Min.		,	Ì		nplace (Sta intry)	te or Foreign
Director		Usual Residence of	1	X M 2 F	5	6	Yrs					11/1/	1951			MI)
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with th		11. Marital Status	derson A	12. Was Dec		er in U.S.			nt of Hisp			ify Yes or N	USA o-	14. Race	ce - American Indian, Black,		
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212 sould b id Meni is mari	일	19a. Informant's N	ame/Relationship	(Type, Print)		- 1	19b. Mailing		(Street	and Numbe	r or Ru	ral Route Nu		•		Zip Code)	
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Baltimore, pernit. Pages I ar Department of He Important: If ite		1 X Burial 2	Cremation			crei	matory or other	ner place)							•		-
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Physician /Medical		23a. Part I. Enter the failure. List or	nly one cause on	each line.				he mode o	f dying, s	uch as card	iac or r	espiratory a	rrest, sh	ock, or hea	ırt	Between	mate Interval n Onset and Death
xaminer	ĺ	Immediate Cause or condition resulti		a. Intraoral G			-		_	_						-	
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760, icate be physici	Med	IF FEMALE: 23b. Was decedent	t present in the	23c. If yes,		of pregnar	ncy			¬			23	d. Date of			
K 6876(n certificate ending physuse as the b	cial	past 12 month		1 Live I	birth nant at time	e of death		tal death her (Spec	3 ∟ cifv)	Ectopic pr	egnand	СУ		Month		Day	Year
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	Physician/M		No 9 Unkno	9 Unkn								T.00. D.					-f don't 2
P.O.	à	Part II. Other sign	ificant condition	s contributing t	o death bu	it not resu	ulting in the i	underlying	cause gr	ven in Part i	•		_	wse contri		-	Unknown
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta	Completed						<u> </u>					24a. Wa					ngs available
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of Vital Records, ng Physician: The law require. Wher this certificate has been sinneral director, page 2 should the	리	examiner? 1 ✓ Yes	2 No		Inpatient		R/Outpatient		<u>υ</u>			Home 5		ence 6		: Scene	
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Division In or Attendin Is after death. In Director: A	ficat	2 Accident 3 Suicide	Investig 6 Could n	28e Plac			640 hrs e, farm, stre	et, factory	office bu	uilding, etc.	2			and Numbe	er or Ru	ral Route I	Number, City
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the Ho nin 24 b the Fur	Medical	29a. Certifier (Check only one) 2	Certifying Phys Medical Examin														
To To To Com	Med	29b. Signature and		and manner	stated			290	. License	number			29d	. Date sign	ed (Mo	nth, Day, Y	ear)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiano		artment of F rtificate of L		, ,	Reg. No.	800	13906
ı	Physici	an	1. Decedent's Name (First, Middle, L	ast)			***		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio	al	Isabel Williams 4a. Facility Name (If not institution, g	ive street and number)			4b. City. Town, or	Location of Death	04/21/2		unty of Death	7:00 a ^M
	LXamin		5418 Kerger Road				Ellicott			How	_	
	Funeral Director		Social Security Number 155-30-9249 Usual Residence of Decedent	Sex 1 □ M 2 □ XF	91	as <i>t birthday)</i> Yrs,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 11/12/1	h y, Yea <i>r)</i> 916	9. Birth Cou	place (State or Foreign intry) NJ
	yland how		10a. State 10b. County		10c. City	, Town or Lo	cation		_			10d. Inside City Limits
	Ba-fsl	Director	MD Howard		Ell	icott	City					1 □ Yes 2 □ No
	23a or 2	ral Dire	10e. Street and Number 5418 Kerger Road				10f. Zip Code 21043			10g. Citizen USA	of What Cou	ntry?
21215-0036	be filed within 72 hours after death with the Maryland ttal Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Ever in at must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 Ⅸ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	Was Decedent of H fYes, specify Cuba I □Yes 2X No	Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecify: Wh:	etc.
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Maryland	be ad a	Be	17. Father's Name (First, Middle, La. John F. Sperry	st)				18. Mother's Nam Anna Hoo		Maiden Sur	rname)	
j X	2 should be and Menta is marked aumatic ev	은	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street a			er, City or To	wn, State, Zi	p Code)
	nd 2 alth a 27 is		Diane Walker / D	aughter			Kerger Ro		cott Ci	ty, MI	21043	3
Baltimore,	e = 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			wridge 1	sition (Name of natory or other plac Memorial Pa	rk 04/24		Elkrid	ion - City or To age, MI)
Ball	permit. Pag Departmen Important; any injury once.		21. Signature of Funeral Service Lic		L378	72	. Name and Addres 250 Washir	ss of Facility ngton Blu	d., Elk	ridge,	, MD 21	1075
	Physician /Medical Examiner		23a. Path. Enter the disease, of confock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. ARTERIO Due to (or as a	SCL a conseque	EROTIC ence of):						Approximate Interval Between Onset and Death & YCHKS
09/89	tificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.	a consequ	ence of):						
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rds, F	requires that the een signed by th nould be detache		Part II. Other significant conditions ATRIAL FIBR	ILLATION	, <u>) </u>	TYPE	I DIAG	BETES	23e. Did to			the cause of death?
Hec Hec	in: The law re ifficate has be or, page 2 sho	Completed by	MELLITUS, TRANSIENT J 25. Was case referred to medical	HYPERTER		o, acks	CAROTI	ARIEWY 26. Place of Deal	24a. Was a autope perfor 1 □ Yes	sy ned?	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
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DIVISION	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 200 Place of Inju	ry - At hor . (Specify,	me, farm, stre		∕es 2□No	28f. Location (S City or Tow	itreet and Ni n, State)	umber or Run	al Route Number,
	le Hospita 24 hours le Funeral letely fille	Medical C	29a. Certifier (Check only one) Certifying F	Physician: To the best of aminer: On the basis of and manner state	examinati	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time, o	cause(s) and date and pla	d manner as ice, and due t	stated. to the cause(s)
	To the vithing To the comp	Me	29b. Signature and title of certifier				29c. License		2	29d. Date si	gned (Month,	Day, Year)
			Hoonju (eni, lus			DS	2832		4	122/0	18
	6		30. Name and address of person who Sovn JA Kim	completed cause of de	sath (Item	23a) (Type, F	Print) IN STRI	ser, E	LKNIDG	e, N	11) 2	21075
	Stat Registra	te ar	31. Date filed (Month, Day, Year) APR 29 2	008 32 Registra	r's Signad	t'e	W					

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State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:45 ^Ma 12, RTHUR April 2008 /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 307 Dominion Lane Queen Anne's Chester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2 □ F 212-54-6448 60 Director March 8, 1948 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show traumatic event, the Medical Evanimer must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Queen Anne's Chester with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21619 USA 307 Dominion Lane Items 23a Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Ples 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No If Yes, Give 1967-73 Specify Specify:White ٥ 3₹Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant; if item 27 Is marked other than' College (1-4or 5+) Elementary/Secondary (0-12) Telecommunications Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Victor Alberding, Sr. Evelyn Crowder ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 Is any Injury or other trau Scott E. Alberding/Son 57 Devon Drive, Port Deposit, MD 21904 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) April 16 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Eurer the disease, or complications that of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1) Month **Physician** as 10 disease or condition resulting in death) /Medical (Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Lectopic pregnancy in the past 12 months? Year Month 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s certificate ha autopsy 1 ☐ Yes Division of Vital 2 No Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1∐Yes 2MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending n 24 hours after death.

The funeral Director: Af olderely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (15m 23a) (Type, Print) 8186 LARK BROWN 31. Date filed (Month, Day, Year APR 15 Year) 32. Registrar's Signature State 2008 Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

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			For State Registrar	State of Marylant		tificate of			Reg. No.	UÜ	13901
*	Physici /Medic		1. Decedent's Name (First, Middle, Last) BETTIE BELLE	ARNOLD				2. Date of De Month	Day	Year	B: 48 A M
April	Examin	4.00	4a. Facility Name (If not institution, give s 25109 OLD HUNDI	i i			r Location of Deat ERSON	h	4c. County		
	Funeral Director		5. Social Security Number 6. Sex 599-44-5819 1□	7. Age (In yrs. la 7 2	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ay, Year)	9. Birthplace Country) MI	e (State or Foreign
	laryland show ed at	or	Usual Residence of Decedent 10a. State 10b. County MD MONTGOI		Town or Loc						Inside City Limits 1 □ Yes 2 No
	with the N a or 28a-f	Direct	10e. Street and Number 25109 OLD HUNDI			10f. Zip Code 2084	2		10g. Citizen of \		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 to No If Yes, Give Year or Dates:	l l		lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - American I	
215-0036	thin 72 ho e. an "natui Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	OO NOT use retire	during most of wo	rking	16b. Kind of Bo		try
2	led wi lygien her th nt, the	Sol	12		нои	SEWIFE	40. Mothor's No.	mo /First Middle	DOME		
Maryland	l be fi	Be	17. Father's Name (First, Middle, Last) JOHN UPTON WHIL	סם פס				me (First, Midale E BELL	e, Maiden Surnan	ne)	
ž	hould d Me mark matic	ျှ	19a. Informant's Name/Relationship (Typ		19h Mailin	n Address (Street	and Number or R			State Zin Co	ide)
<u>8</u>	d 2 s Ith an 17 is i		DEBBY KIDWELL				UNDRED		-		•
<u>ق</u>	tem 2		20a. Method of Disposition	20b. Pl	ace of Dispo:	sition (Name of	i	Date	20c. Location -		
E	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State BO	YDS P	RESBYTE CEMETER	RIAN 4/	16/08	BOYD	S, MD	
Baltimore,	partm portal y inju		21. Signature of Funeral Service License		22	. Name and Addre	ess of Facility		L		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	. Do not ente	O BOX	UNERAL 86, BA	ARNESVI	T.L.F., MI arrest,	Ap	3 3 8 proximate derval Between nset and Death
68760,	tificate be executed g physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
O. Box 6		sician/IM	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M/No 9 □ Unknown	Bc. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnanc	у			te of delivery onth Da	y Year
Hecords, P.	The law requires that the death ce te has been signed by the attendir age 2 should be detached for use	ed by Phys	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause giv	ven in Part I.		tobacco use cent Yes 2 No		ause of death? y 4 ∐Unknown
	40 CT	Completed							opsy ormed/	prior to comple death?	findings available etion of cause of No
VIta	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:		T _{Oth}	nor:	ath (Check only			
	ding Physician: h. After this certific funeral director,	ion: To	27. Manyler of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wor	4 LI Nursing i		idence 6 Oth how injury occur		
Division or	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre				(Street and Numb wn, State)	er or Rural Ro	oute Number,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of my know ler: On the basis of examinat and manner stated.	vledge, death ion and/or in	vestigation, in my	opinion, death occ	e, and due to the curred at the time	e cause(s) and many date and place,	anner as state and due to the	ed. e cause(s)
)	To the within 2 To the complete	Σ	29b. Signature and title of certified	alen a	W	29c. Licens D00	64615		29d. Date signe		
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DHMH 17 Rev 1/2001

State Registrar

GENEVIEVE WROBLEWSKI, MD 1355 PICCARD DR., ROCKVILLE, MD 20850

1.5 2008 Registra's Signature

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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eale churchton 32. Registras Signature 2008

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 50653

Road.

GYAN - C. SURANA

29d. Date signed (Month, Day, Year)

4-8-2008

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The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, has certificate Hospital or Attending Physiclan: this After

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** \mathbf{A}^M Nancy Rock Boyd Apri1 17 2008 0900 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton Ceci1 50 Bonney Shore Road If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F SEPT 27, 1931 Pennsylvania Director 171-26-5181 76 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 💢 No Directo Cecil Elkton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Bonney Shore Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be fi ealth and Mental F n 27 is marked otl Helen Robert Rock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Allan C. Boyd/Husband 50 Bonney Shore Road, Elkton, MD 21921 Important: If item 2 any Injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 18. 20a. Method of Disposition 1 ☐ Burial 2 MiCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 R. A. Ferris & Co., Inc. West Chester, PA 22 Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ician Car dical Due to (or as a consuluence of): niner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit Due to (or as a consequence of): by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ed by the a I□Yes 2☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vonknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 12 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD HOOG2851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkton 140 21921 1Kobert3 301 -air 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.--2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2²2 APRIL 2008 MARVIN DAVID BARRY 4:15p M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chestertown Chestertown Nursing Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 29 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F 81 1927 Alabama Jan 218-20-7100 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 ☐ No Kennedyville Director MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 U.S.A. 21645 12028 Augustine Herman Hwy Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner mu 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Work Release State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William Barry Anna Mae Hall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) t of Health a Anna Barry 12028 Augustine Herman Hwy. Kennedyville MD other t Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Kennedyville Cem. 4/25/08 Kennedyville, MD. 4 Donation 5 Dother (Specify) 21. Signature of Juner Berviol in anse 22. Name and Address of Facility Galena Funeral 118 West Cross Home of Stephen L. Schaech St. Galena, MD. 21635 M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIO PULHONAND APPRENT **Physician** /Medical Examiner ementea with POOK DUANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes VASular And Anterial Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 23889

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arrabal, M.D. 223 High St. Chestertown, MD. 21620 John C.

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 922 N241 AJ Bullino MID 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April P\$,2008 Physician 5:18PM M Baucum Henry Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles La Plata Center Medical Civista If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 7,1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 11X M 2□ F NC 579-40-8346 8.5 May Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director Charles Welcome Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20693 8215 Harry Warren Place USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ Black Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Local Government Nurse 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgianna Bennett .Iohn Baucum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Corada Baucum/Wife 8215 Harry Warren Pl.,Welcome, Md. 20693 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Zion Baptist Cem 4/19/08 4 ☐ Donation 5 ☐ Other (Specify) Welcome, Md. 22. Name and Address of Facility Bluford Funeral 21. Signature of Funeral Service Licensee Service Chrylle D 2019 MLK Ave., SE, Washington, DC 20020 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 ☐ Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe this certificate 1□ Yes 2 1100 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tes 2 DER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Mann of Death completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) Injury 1 Unatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 - ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29c. License number 29d. Date signed (Mointh, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 5100 Auth Rd., Suitland, Md. 20746 Yeldell, Crystal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Month Physician 12:00p Elsie G. Burmeister Apri1 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F Yrs. 79 Director 27,1928 532-22<u>-2248</u> Missouri Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1X Yes 2 No Directo Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1421 Taney Avenue # 606 21702 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Retail Clerk</u> Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H tem 27 Is marked ott Be ို James Maurice Malone Elizabeth Albert Hix 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Dennis Burmeister/ Son 1308 N. Oak Cliff Court, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 4/14/08 Frederick, Maryland 21. Signature of Freral Service 22. Name and Address of Facility Stauffer Funeral Homes P. A. Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition.) Immediate Cause (Final orgestive disease or condition resulting in death) Due to (or as a consequence of): monic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and buriaf-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ tension 2 No 3 Probably 4 ☑Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No aneli 24a. Was an certificate has autopsy perform 1□ Yes 2 No

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

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Certification: To

Medical

The law requires that the death certificate be executed

Physician:

Hospital or Attending

after death Director:

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Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e cause(s)

29a. Certifier (Check only one)		y knowledge, death occurred at the time, date and place, and d mination and/or investigation, in my opinion, death occurred at	
20h Signature an	d title of certifier	29c. License number	29d Date signed (Month, Day

-14-08 D 0054636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008▶

Syed W. Haque MD 700 Montclaire Avenue, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrans Signature

State Registrar

P.O. Box 68760, Division or Vital Records,

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and physician the as attending for use ed by the a signed b d be deta page 2 should certificate has furieral director, After this 24 hours after death. filled in by To the I within 2

2 Accident 3 Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cat Works

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13026 Thyme MD 20874 29a. Certifier (Check only one)

29c. License number

D006-0747

29d. Date signed (Month, Day, Year)

MD

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

1 homas

31. Date filed (Month, Day, Year) APR 15 2000

30. Name and address of verson who completed cause of death (Item 23a) (Type, Print)

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1			For State	State of Ma	ryland / Depa			Mental Hyg	giene		
			Registrar		Cei	rtificate of	Death		Reg. No. 2	08,139	917
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	/Medi		MAR 4a. Facility Name (If not institution, given		CIZEK	4h City Town	or Location of Death	APRIL	11, 20		A IVI
7	Examir	ıer			DIMAI						
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	Director		213-56-6221	X]M 2□F	57 Yrs.	Months Days	Hours Min.	NOV. 2		WASH. D.	С.
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ယ္	after or Iter		1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 🕱 N	0			o Rican, etc.)	77535	, White, etc.	
03	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🔀 No	Specify:		Specify:	WHITE	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of wor ed)	king	16b. Kind of Bus	siness/Industry	
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J. C	es 1 and 3 of Health litem 27 rother tr		20a. Method of Disposition		20b. Place of Dispo cemetery, cre			Date		City or Town, State	
Baltimore,	Pa ant: ury		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Speci</i>				ORY 4-16	-2008	RIVERDA	ALE, MD.	
alt	permit. Pag Department Important: I any Injury o	ŀ	21. Signature of Funeral Service Lice	asee	2:	Name and Addr					
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W.	/Medical Examiner			Due to (or as a	a consequence of):						
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8760,	cate be executed physician and the burial-transit	dical		_ d							
9	ertifica ing ph	Med	IF FEMALE:					*			
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 ☐ Fetal death 3 [☐Ectopic pregnanc	су		23d. Date Mor	e of delivery hth Day Y	'ear
	the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)_			IVIOI	illi Day i	eai
P.0	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as		Part II. Other significant conditions	contributing to death bu	at not resulting in the u	nderlying cause gi	iven in Part I.	23e. Did to	bacco use contr	ibute to the cause of de	eath?
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Vital			25. Was case referred to medical				OS Disso of Day			□Yes 2□No	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	ical	(Check only 2 Medical Exa	nysician: To the best on the basis of the basis of	examination and/or in	th occurred at the to restigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s))
	thin 2 the orthe	Medical	one) 29b. Signature and title of certifier	and manner sta	ted.	29c Licen	se number.		29d Data signer	i (Month, Day, Year)	
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	10 0		30. Name and address of person who	completed cause of de	eath (Item 23a) /Tune				111114	14, 2008	5
			JAMES K. LIGH			,	L AVE., T	ΑΚΟΜΑ ΡΔ	RK. MD	20912	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Khushnud Ahmad Chaudhry 5:40 PM 2008 4 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 219-55-1275 68 Director 8/9/1939 Pakistan Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at Md. Montgomery Brookeville 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 2608 Sunshine Ct. 20833 Pakistan Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The man 27 is marked other than "natural", or items 23a and it if them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Completed by Specify: Asian 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed none 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gulam Oadir Sadar Bibi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2608 Sunshine Ct., Brookeville, Md. 20833 Zack Cheema /son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 Cremation 3X Removal from State 4/18/08 Lahore, Pakistan 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 21. Signs ture of Funeral Savice Licens 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if you allow to him late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical attending physic for use as the b IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No cate has autopsy performed? Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3K DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: / ō Hospital

State

Steve.~ 31. Date filed (Month, Day, Year) 15

29b. Signature and tille of contifier

29a, Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24348

29d. Date signed (Month, Day, Year)

1500 Forest Glen Rd. Silver Spring, Md.

4-13.2008

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	
*	Physici		Maria E. Chacon		April 13,	2008 1:30 a	М
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Sligo Creek Nursing & Rehab.	Takoma Park		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Forei	ign
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	the A	Director	Maryland Montgomery Si	lver Spring 10f. Zip Code	100	Citizen of What Country?	
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Maryland 21215-0036	nd 2 shoulth and N 27 Is main		19a. Informant's Name/Relationship (Type, Print) Jose A. Reig/Nephew 19b. Mail	ng Address (Street and Number or Rural 5909 Wild Flower C	Route Number, Ci Court, Des	ty or Town, State, Zip Code) rwood, MD 20855	i
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Meniz Importent: If item 27 is marked any injury or other treumatic e pages.		1 Hurial 2x XCremation 3 Hemoval from State		1 15,	. Location - City or Town, State	_
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	Se OG	þ	Part II. Other significant conditions contributing to death but not resulting in the Metastatic Bone Cancer	underlying cause given in Part I.		2 ☐ No 3 ☐ Probably 4 ☑Unknow	
orc	w require been si should t	ted	The captacia Bone Ganger		1 103		
Vital Records,	≥ 0 0	Completed			24a. Was an autopsy	24b. Were autopsy findings availate prior to completion of cause of	
Ξ.		Con			performed 1 Yes 2		
/ita	Phyeician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	Phyei this o	2	1 ☐ Yes 200 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie				_
		lon	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	Work?	8d. Describe how i	njury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	29f Location (Stron	t and Number or Burn! Bouta Number	
Division	- 9	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, single building, etc. (Specify)	reet, factory, office	City or Town, S	t and Number or Rural Route Number, Itate)	
	To the Hospital or within 24 hours aft To the Funerel D completely filled in		29a. Certifier XXCertifying Physicien: To the best of my knowledge, dea	th accurred at the time data and aleas a	nd due to the ocus	e(c) and manner as stated	
	Hos 24 hc Fun etely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
	_			C114-	7	4/16/10	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		1/1/0	
•			Nasreen M. Kango, MD 7610 Carrol	l Avenue, Takoma Pa	ark, MD 2	09/12	
	× Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	Registi	A 15	APR 15 2008 France & A	and I			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryl	and / Depa <i>Ce</i>	artment of H rtificate of	lealth ar <i>Death</i>	nd Menta	Hygid Reg	ene 2	008	13920
	hysicia		Decedent's Name (First, Middent MARGARET		CONRAD				2. Date	of Death	.7 ^{Day} 20	08 ^{ear}	3. Time of Death 1:15 A M
	/Medic Examin	15	4a. Facility Name (If not institution FREDERICK			Γ λ Τ.	4b. City, Town, o		Death			ty of Death	
	ineral rector	×	5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		Min. (Moi	of Birth oth, Day, 1	Year)	9. Birth Cou	place (State or Foreign ntry) 11and
ıryland	show d at	_	Usual Residence of Decedent 10a. State 10b. Count	у	100	. City, Town or Lo	ocation						10d. Inside City Limits 1 X Yes 2 □ No
th the Ma	or 28a-f s e notifie	Director	Maryland Fred 10e. Street and Number	erick		Frede	erick 10f. Zip Code			10	g. Citizen o	f What Cou	
ath wi	s 23a nust b	eral [1599 Carey Pla		ecedent Ever	in II S 12	2170		in? (Specify Ve	s or No-		SA ace - Ameri	ican Indian,
rs after de	I", or item xaminer n	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed 1 \(\text{Yes}. \)	Forces? s 2 ☑ No	13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Puerto Rican, é	etc.)		ack, White	
ire, INIAI yiaild ZIZIS-DOOO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.	n "natura Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade complete	d) e (1-4or 5+)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	1	6b. Kind of	Business/Ir	ndustry
d with	t, the l	Com	12	0		He	omemaker	L 40 . M. W	la Na mana (Filma)	0.01-01-0-0.0		own he	ome
d be file	event	Be	17. Father's Name (First, Middle						's Name (First,			ame)	
Should Should of Mei	mark	욘	William Lee Ha 19a. Informant's Name/Relation			19b. Mail	ng Address (Stree		a Leah r or Rural Route			n, State, Zi	ip Code)
and 2 s	27 is er trau		Faye R. Bevard	- daught	er	1599	Carey P	lace,	Frederi				
Pages 1 anent of He	Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fro	om State	Ob. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ace)	Date	2	0c. Location	n - City or T	Fown, State
rmit. Pages	rtant: njury o		4 □ Donation 5 □ Other	(Specify)			en Cemete		/21/08				Maryland
pall. permit. Departr	any lr		21. Signatur uneral Service		"mest	(/			LITITIT		unera: town.		e 1and 21740
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications the	at caused the								Approximate Interval Between
Phys	sician	74 H	Immediate Cause (Final disease or condition	a (MAC	liar.	ar	whit	hmi	2			Onset and Death
	edical miner		resulting in death)	Due	to (or as a cor	nsequence of:							
	हेन्	er	Sequentially list conditions,	b	to (or as a co	nsequence of):							
cuted	d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	6									
e exec	iian an urial-tr	Exa	resulting in death) Last	Due	to (or as a co	nsequence of):							
ocrtificate be executed	physician and s the burial-transit	dical		d									
.O. Box of the death certifi	certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 □ Li· 4 □ Pr	outcome pf prove birth 2 are egnant at time or hown	Fetal death 3	□Ectopic pregnan □ Other (specify)	су				Date of deli Month	ivery Day Year
COLDS, P.	n signed by Id be detac	by	Part II. Other significant cond	itions contributing t	o death but no	ot resulting in the	underlying cause g	iven in Part I.	23	e. Did tob			the cause of death?
The law req	te has beer age 2 shou	Completed								a. Was ar autops perform	у	b. Were au prior to death? 1 ☐ Yes	itopsy findings available completion of cause of
ITal	ertifica ctor, p	Be C	25. Was case referred to medic examiner?						of Death Chec				
Or VITA Physician:	this or al dire	은	1 ☐ Yes 2 No 27. Manner of Death		Inpatient ate of Injury	2 ☐ ER/Outpation	all DOY		rsing Home 5		ence 6 🗆 0		cify)
On o	After	tion	1 Natural 5 ☐ Pend	//	Aonth, Day Ye		W	ork? ☐Yes 2☐N		2001100 110	,,		
DIVISION of the Hospital or Attending Figure 24 hours after death.	To the Funeral Director: After this certific completely filled in by the funeral director,	ertification:	3 ☐ Suicide 6 ☐ Coul	rminod 200. F	ace of injury - uilding, etc. (S	At home, farm, s	treet, factory, office	÷	28f. Lo	cation (Sti y or Town	reet and Nu n, State)	m <i>ber</i> or Ru	ural Route Number,
e Hospita 24 hours	e Funera letely fille	Medical C	29a. Certifier 15 Certification (Check only one)	ying Physician: To al Examiner: On the and r	the best of m ne basis of exa nanner stated.	amination and/or	ath occurred at the investigation, in my	time, date and opinion, deat	d place, and du th occurred at t	e to the ca he time, da	ause(s) and ate and plac	manner as ce, and due	s stated. e to the cause(s)
To the P	To th comp	Me	29b. Signature and title of certi	filer	0 ^		29c. Licer	nse number	2050	25	9d. Date sig	ned (Mont	h, Day, Year)
SH	-5		30. Name and address of personal (2)	on who completed	cause of death	(Item 23a) (Type	Print 7	Forh	rich	, /	NID	21	707
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea		2. Ragistrar's	Signature	fort						

DHMH 17 Rev 1/2001

Certificate of Death

State Registrar

DHMH 17 Rev 1/2001

within 2

APR 16 2008

RADIA

29b. Signature and title of certifier

GHAZAVA

31. Date filed (Month, Day, Year)

M(I)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TAGUMDUN

29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

APR 14 2008

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 50 Ø M Alta Lula Carbaugh April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Hagerstown Washington Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Days 1 □ M 2X F Months 93 Maryland Director 29,1914 219-22-7586 April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with iral", or items 23a Examiner must b 21795 USA 15530 Clear Spring Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Production Assistant Toy Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward William Bair Lottie Redrea Householder ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Palmer - Niece 15912 Falling Waters Rd. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 5 ☐ Other (Specify) Cedar Lawn Mem. Park:04-17-2008 | Hagerstown, Maryland 4 Donation 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Juneral Second 425 S.Conococheague St. Williamsport, MD 21795 Partr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My ocarde arction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day signed by the al d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 □ No 2 1 NO 1 TYes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 1 Impatient 2 ER/Outpatient 3 DOA 2 this To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

APR 1 6 2008

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

un 32. Red

trar's Signature

WAHERD

2821-OAKHILL AVE HAGERSTOWN. MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2:48 a M Dorothy Ann Dwyer 12 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 K Yrs. 76 February 29,1932 District of Columbia **Director** 577-40-1205 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show important; if Item 27 is marked other than "natural", or Items 25a or 28a-f show important; if Items 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 U.S.A. 15003 Haslemere Court Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William B. Witte Jessie I. Fowler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Dwyer - Son 3940 Sugarloaf Drive, Monrovia, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 04/17/2008 Rockville, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell Lung Cancer Months /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an

page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p Be Certification: To n 24 hours after death.

In Funeral Director: Af

performe 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Hospice

25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No

27. Manner of Death

2 Accident

3☐ Suicide

4 Homicide

1 Natural

28a. Date of Injury 5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🛎 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

title of certifier

29c. License number

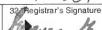
29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (item 23a) (Type, Print) POBOX 83819

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 5





			for State	State of Marylar					and M	lental Hy	gien	e 200	Q	13025
			Registrar	-0	Cei	rtificate	of L	eath			Reg. N	o. C U U	0	13720
	Physici	an	1. Decedent's Name (First, Middle, La Elizabeth Findl	_					İ	2. Date of De Month	D	ay Yea	r	Time of Death
1	/Medic					4h City T		Location	4 Da adh	April				:25 p M
	Examir	ier	4a. Facility Name (If not institution, given Sligo Creek Nur			4b. City, To		Park	of Death		40	C. County of De		
1			5. Social Security Number 6. 9		last hirthday)	If Under 1		If Under 2	24 Hrs. T	8 Date of Bir	th	Montg		Y (State or Foreign
п	Funeral Director			1 M 2 M F 96	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April	iy, Year	1912	Country)	yland
			Usual Residence of Decedent	130						Whili	 ,	1314	Mai	yland
	ylanc how	١.	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation							10d. I	nside City Limits
	a-f s	당	Maryland	Montgomery	Tako	ma Pai	ck						1	X∏Yes 2☐No
	or 28	ie	10e. Street and Number			10f. Zip C					10g. C	itizen of What	Country?	
	23a	Funeral Director	20 Montgomery A	venue		20	912					USA		
	ems	ne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))	14. Race - Ar Black, Wh		idian,
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 k No If Yes, Give		1 □ Yes 2	-	Specify:				Specify:		
21215-0036	uraľ	d b	3 ₩ Widowed 4 Divorced	Year or Dates:	T 40- P	dente (Invel	0	A1			401	W	hite	
15	n 72 "nai	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual <i>kind</i> of work DO NOT use	done di	uring most	of worki	ng	160.1	Kind of Busines	s/industr	y
112	withi iene.	l L	Elementary/Secondary (0-12)	College (1-4or 5+)	3.5	edical	,		an			Medic	- I	
	filed Hyg Sther ent,	Be C	17. Father's Name (First, Middle, Last		1 17	earca.				(First, Middle,	. Maide		<u>a. </u>	,
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Institut Exposite traust to notified at	To B	John Findlay					Davi	na S	Stewart	Gra	av		
ary	shou ind N	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street a					or Town, State	, Zip Coa	'e)
	1 and 2 Health a em 27 le	ĺ	Mary Barber/Daug	hter	122	2 Warr	202	Stroc	.+ I	onaina	ton	MD 20	005	
ē,	other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of	i	D	ate	20c. l	ocation - City	or Town,	State
E	Pages nent of I int: If ite iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Hemoval from State	tropol				, -	oril 14	78.	1		
Baltimore,	# t t t =		21. Signature of Funeral Service Lice		24	Name and	Addres	s of Facility			I II	me Inc	la V	irginia
Ω	Depared Important any Irreported and Irreported and		2022 30	John .	1									MD 2090
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-	Physician		Immediate Cause (Final disease or condition	Alzheimer'	e Dieo	200							Ons	et and Death Years
	/Medical		resulting in death)	Due to (or as a consec		ase							- 2	rears
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\	₽ 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):									
)	ecut and -trans	хаш	that initiated events resulting in death) Last	c Due to (or as a consec	wonee of:								<u> </u>	
60,	icate be executed physician and the burial-transit			Due to (or as a consec	querice oi).									
68760,	phys the	dical		d									+	
×	eath certifi attending for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv							23d. Date of	in live w.	
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	aldeath 3□	Ectopic pre Other (spe					İ	Month	Day	Year
0	at the de by the tached	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown									_	
ď.	ee ≆		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cau	ıse give	n in Part I.		23e. Did t	obacco	use contribute	to the ca	use of death?
rgs	quires in sign ald be	d by	Hypothyroid							1 🗆 '	Yes 2	2 □ No 3 □	Probably	4 □XUnknown
၀	sw requir s been s s should	Completed								24a. Was	an	24b. Were	autopsy f	indings available
æ	: The law cate has page 2 s	E O									rmed?	death	?	tion of cause of
ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	ne)	0 1111	es 2 🗆	NO
of Vital Records,	di is		examiner? 1 ∐ Yes 2 ဩrNo	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 DDA	Otho	r.				6 ☐ Other (S	ecify)	
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	15	}	30. Name and address of person who		m 23a\ /Time	Drint\								
			Carolyn Hammett,				d, I	E, #2	26,	Langle	y Pa	ark, MD	2078	33
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month HORII Phyllis Ilene Dofflemyer 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2 🔀 F 83 217-18-8336 02/17/1925 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 217 No MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 21740 13137 Maugansville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify. Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine (unk) Barnhart James E. Hovis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Dwight D. Dofflemyer 13208 John Lindsay Road, Greencastle, PA 17225-9666 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 04/18/2008 Hagerstown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Ligensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (o' as a consequence of) 2au Due to (or as a consequence of) 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 2 Fetal death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examin

and

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any injury or other traumatic event, the Medical Examiner once.

Saltimore, Maryland 21215-0036

death with the

Funeral Director

Completed by

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as the burial-transi attending physician for use as the buria 24 hours after death

Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Acciden 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D21457

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OAKHILL AVE. HAGERSTOWN. MD 21742 WAHEED Mn

31. Date filed (Month, Day, Year) APR 17 2008



State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items State of Maryland / Department of Health and Mental Hygiene 28a-f per me, g879, 05/08/08dbb Death

Registrar

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1008 Catherine Marie Deems /Medical 4c. County of Death 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. Sept. 17, nmore 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 7, 1932 Delaware 1 M 2 X F 75 **Director** 221-20-0774 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show the Medical Examiner must be notifled at 1X Yes 2 No Baltimore Maryland Owings Mills "natural", or items 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 Atrium Court Apartment 625 21117 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles John Brown Laura Mae Blackson and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains Erin Cazares / Daughter 575 Overland Court, Bonita, California 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Apri1 North East, Maryland St. Mary AnneCemetery 18, 2008 22. Name and Address of Facility Crouch Funeral Home 21. Signalur of Fun Tai S pi e censee 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and 2 and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical requires that the death certificate as led by the attending detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has autopsy performe Vital within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ō 28a. Date of Injury (Month. Day Year) 28b. Time of 28d. Describe how injury occurred **Probable fall.** 27. Manner of Death 28c. Injury at Work? Certification: Division 1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation 04/01/2008 **Unknown**^M 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4/30 Atrium Village Apt. 625, Owings Mills, Maryland determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 Milwathowsan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State APR 1 5 2008

DHMH 17 Rev 1/2001

Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give				*		Location of Death			c. County			
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	trylan thow	_	10a. State 10b. County		10c. City, T									10d. Inside City Limits 1 ☐ Yes 2 X No	
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	be filed within 72 hours after death with the Marylar that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number	D			10f. Zip C		21710		10g. C			,	
	ns 23 must	Funeral	5526 Tracey Bruce	12. Was Decedent	Ever in U.S.	13. \	Was Deceder		21710 spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No	0-	14. Red	e - Ameri	tates can Indian,	_
စ	or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No		if Yes, specify 1 □ Yes 25		n, Mexican, Puerto Specify:	Rican, etc.)		Specif	ck, White		
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90,	e execian a		resulting in death) Last	Due to (or as	a consequer	ice of):				Man				days	
687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical		d	ay					, Mi				0,000	
Box	certiff nding use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Da	ate of deli	very	
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	the Ho in 24 I the Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner st		n and/or in	_			rred at the time					
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	Regist	ar	APR 1	4 2400	WARRAN .	1	1								

Physician /Medical **Examiner**

Department of H Important: If ite any Injury or of

Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

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Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

attending physician for use as the buris 24 hours after death

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	MYOCOLYCA	7/ M/c	urchon		Mours
Sequentially list conditions, a.y. cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent	ench's	Cerevary	Adeny	disare years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 ☐Ectopic pre			23d. Date of delivery Month Day Year
Part H-Other significant conditions con	ntributing to death but not resulting MDMUS.	g in the underlying ca	use given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Onvancobs	emig active Pul	many	Disease	24a. Was an autopsy performed 1 Yes 2 X	
25. Was case referred to medical examiner?	Hospital:		Other	ath (Check only one)	
I Tes 2 Delo	1 Inpatient 2 EH/		4 Nursing I		6 □Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	b. Time of Injury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory	office	and Number or Rural Route Number, ate)	
29a. Certifier (Chec nly one edical Example)	siclan: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred a and/or investigation,	at the time, date and plac in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and the of ceptier	1 1	29c.	License number	29d.	Date signed (Month, Day, Year)

Registrar

State

completely within 24

> 31. Date filed (Month, Day, Year) 2008

John R.

Mulvey, M.D., 111 West High St., Suite 309, Elkton, MD Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			1. Decedent's Name (First, Middle, Last,								Date of Deat Month	h Day	Year	3. Time of	Death
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	Examin		4a. Facility Name (If not institution, give	street and nu	nber)		4b. City,	Town, or	Location of D	eath		4c. County	of Death		
			ATLANTIC GENERAL	HOSPIT	AL		В	ERLI	N			WORCE	STEF	}	
	Funeral		5. Social Security Number 6. Sec		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Ain.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or	r Fo reign
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	tems	Funerai	11. Marital Status	Armed Fo	edent Ever in U proes?	J.S. 13.	Was Deced If Yes, spec	lent of Hi of Cuba	spanic Origin? n, Mexican, Pi	? (Specify uerto Rica	Yes or No- an, etc.)		k, White	ican Indian, , efc.	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Gir Year or D	2X No		1 ☐ Yes	2 💢 No	Specify:			Specify	: 1711	ITE	
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04/11 10 19 19	Q 5 Q •	ToB	SAMUEL J. ROLPH						MABLE	М	IEHLE				
	EBEE	-	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address	(Street a				City or Town,	State, Zi	p Code)	
DOD re, Ma	12 12 12 13 13		TIMOTHY R. EBNER,	SON		13990	MATE	R WA	Y, MT.	AIR	Y, MD	21771			
ē,	- I = 2	- 2.	20a. Method of Disposition			Place of Dispo	osition (Nan	ne of	D	Date		20c. Location -	City or T	own, State	
OF.			1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from	State	MATORY	-			12_2	008 T	ELMAR,	DE		
$\mathcal{D}_{\mathcal{K}}$ Baltimore,	a training		21. Signature of Juneral Service Licens	94	(A)		2. Name an		-	12 2	000 1	LIBITATIN	DL		
(1 -	Depril		Auber 11	Hon	Vin	a / HA	STING	S FU	NERAL	HOME	, SELE	YVILLE,	DE		
CZ			23a. Part1. Enfer the diseas, or compl	ications that o	aused the									Approximate	ə
	Dhysisian	8 8	shock or heart failure. List only of Immediate Cause (Final	ne cause on e	each line.	11							14	Interval Betw Onset and D)eath
	Physician /Medical		disease or condition resulting in death)	Due to	(or as a conse	TIC SI	hock								
12	Examiner			200.10	1000	10.00								1 de	111
02		er	Sequentially list conditions,	Due to	or as a conse	direction off.	J		-					, 0,0	14
	uted d ansit	Examiner	Sequentially list conditions, a.y. Court of the cause. Enter Underlying Cause (Disease or injury that initiated events	43.0										Ide	11
DOB 760,	exector and and and and and and and and and and	Exa	resulting in death) Last	Due to	(or as a conse	quence of):									0
	ate be executed hysician and he burial-transit	cal		J											
89	leath certificat attending phy I for use as the	ed													
/ ×	h cer endin	Physician/Med	230. Was decedent pregnant	3c. If yes, ou	fcome of pregn		⊒Ectopic pr	eanancy				1	e of deliv		
bne 35 0.8	ie deat the attr hed for	icia	in the past 12 months? 1 Yes 2 No	4☐ Pregr	ant at time of		Other (sp					Мо	nth	Day Y	/ear
17.0°P	that the d ed by the detached	hys	9 Unknown	9□ Unkn	own										
S, T.	The law requires that the death certifica ste has been signed by the attending ph bege 2 should be delached for use as if	by P	Part II. Other significant conditions co	ntributing to d	eath but not re	sulting in the u	inderlying c	ause give	n in Part I.		23e. Did fot	acco use cont	ribute to	the cause of de	eath?
	w require been sig									_	1 □ Y€	s 2 No	3 Pro	bably 4 DU	Jnknown
ine R 12 - Record	law requas been 2 should	Completed								[24a. Was a autops		Vere auf	opsy findings a	available
	The I	E								_	perform	ned?	death?	2 2 1 00	1036 0
The Sital		0	25. Was case referred to medical						26. Place of	Death C	heck only on			350410	
2 = 5	ysici is ce direc	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital:	Inpatient 2] ER/Outpatie	nt 3 DC	Othe	r: 4 ☐ Nursir	ng Home	5 🗌 Reside	ence 6 □Oth	er (Spec	ify)	
₹ 40	ding Ph J. After thi funeral		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o	of 2	8c. Injury Work	at ?	28d	. Describe ho	w injury occur	ed	-	
<u>.</u>	Attending Physician: r death. ector: After this certific by the funeral director.	atic	1 Natural 5 Pending 2 Accidenf Investigation		.,,,	,,	М		res 2 □ No						
Division	for Attend after death Director:	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		of Injury - At h		reet, factory	, office		28f.	Location (St City or Town	reet and Numb	er or Rui	ral Route Numi	ber,
Ō	rs aft	Certification:													
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Phy (Check only one)	ner: On the b	besf of my kn asis of examin ner stated.	owledge, deal ation and/or in	th occurred ivestigation	at the tim , in my or	e, date and p sinion, death o	elace, and occurred	due to the ca at the time, da	ause(s) and ma ate <i>a</i> nd place,	nner as and due	stated. to the cause(s))
	To th Withir To th	Me	29b. Signature and title of certifier					. License				9d. Date signe			
	0		Da. La P.	000	MI		7	500	62670	`		4/12/20	208		
	Jan		30. Name and address of person who co	mpleted cau:	se of death (Ite	m 23a) (Type.	, Print)		(1	4/12/20 Poxon	-0		
	2		David Reede	- m	D	500	Mari	(et	St. S.	i+e	101	Poxon	o Ke	mel	
	Sta	ite	31. Date filed (Month, Day, Year)	/ 32. F	Regisfar's Sign	nature		ا مر		, , , ,		1 32011	1	77.101	
1	Registr	ar	APR 15	2008	Distance.	15	CONT.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year April 8, **Physician** 11:52 Ennis Marjorie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury 418 Monticello Ave. If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours 220-26-2815 1 □ M 2 🕱 F 1/4/1922 England Director 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at 1 XYes 2 No Wicomico Salisbury Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number d other than "natural", or items 23a or event, the Medical Examiner must be 21801 USA 418 Monticello Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white 2 3 X Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M hospital gift shop general helper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Bennett Arthur Noony Jackson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1220 Weddel Ave., Baltimore, MD 21229 Paula Mihm/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/08 Salisbury, MD Wicomico Memorial 4 Donation 5 Dother (Specify) Park 21. Signature of Funeral Service Livins 22 Holloway Funeral Home Professional Association 164 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and the burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical the as attending properties for use as 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth 2 Fetal death Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed2 1 Yes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only orfe) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 2 After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Phy 29a. Certifier sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical clical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature completed cause of death (Item 23a) (Type, Print) of person who 31413 Winterplace Pkwy, Salisbury, MD 21804 Mitchell **Gittleman** Dr. 31. Date filed (Menth

State Registrar 1 4 2008

32 Registrar's Signature

Phys /Me Exar

Funer Directo

	4	For State 0	f Maryland /	-			nd M	ental Hy	giene				
		Registrar		Cert	tificate of L	Jeath			Reg. No.	008	3. Time of Death		
ician	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y									11.270		
dical		Delores G. Farnella April 13, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of									78		
niner		Laurel Regional Hospita			Laure		Dodin		-		George's		
al		5. Social Security Number 6. Sex	7. Age (In yrs. last t	oirthday)	If Under 1 Year	If Under 24		8. Date of Bir (Month, Da		9. Bir	thplace (State or Foreign		
or		213-38-7296 1□M 2XF	68	Yrs.	Months Days	Hours	Min.		5, 19		laryland		
	-	Usual Residence of Decedent 10a. State 10b. County	10c, City, To	wn or Loc	ation						10d. Inside City Limits		
5											1 ☐Yes 2X No		
Director	1	Md. Howard 10e. Street and Number	EIK	ridge	10f. Zip Code				10g. Citize	en of What C	ountry?		
		7913 Mayfield Avenue			21075					USA			
Funeral			edent Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origi	in? (Spe	cify Yes or No		I. Race - Ame Black, Whi			
E.		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes			Tes, specify outla	Specify:	I delle I	noan, etc.,		Specify:	ie, etc.		
Completed by		3 ☐ Widowed 4 ☐ Divorced Year or Di	ates:							N	Mite		
lete		15. Decedent's Education (Specify only highest grade completed)		a. Decede Give k! life. D	ent's Usual Occupa ind of work done o O NOT use retired;	ation luring most ()	of workir	ng	160. Kind	d of Business	/industry		
Ĭ		Elementary/Secondary (0-12) College (1	-4or 5+)	_	wner				Re	staura	int.		
Be		17. Father's Name (First, Middle, Last)			7,11101	18. Mother	's Name	(First, Middle					
P B		James Albert Guyaux				Mar	y A	ngelin	a Ber	tucca			
		19a. Informant's Name/Relationship (Type. Print)	I .		Address (Street a						Zip Code)		
	34	Anthony L. Farnella			Sharp Rd	. Gle							
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City									_		
	ļ	4 Donation 5 Other (Specify) Ardent Crematory 4/15/2008 Hanover, N											
once		21. Signature of Funeral Service Apense MOO845 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043											
		23a. Part I. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
n		disease or condition resulting in death) a. COPD exacerbation											
al r		Due to (or as a consequence of): Pneumonia											
			or as a consequence	e of).									
٦	1	Cause (Disease or injury HVDO:	tension Se		3								
Examiner		that initiated events resulting in death) Last	or as a consequence	e of):									
dical		d											
Med	+	IF FEMALE:						-					
l/ue		23b. Was decedent pregnant	come pf pre gnan cy irth 2□Fetal dea		Ectopic pregnancy				23	d. Date of de	elivery Day Year		
Physician/Me		1 ☐ Yes 2 No 4 ☐ Pregn 9 ☐ Unknown 9 ☐ Unknown	ant at time of death own	5□	Other (specify)					onai	Day Four		
		Part II. Other significant conditions contributing to de	eath but not resulting	in the und	derlying cause give	n in Part I.		23e. Did t	obacco use	e contribute t	o the cause of death?		
Completed by			·		, , ,			1 🗆	Yes 2□	No 3□P	robably 400nknown		
ete								24a. Was	an	24h Were a	utopsy findings available		
E C								auto perfe	psy prmed?	prior to death?	completion of cause of		
Be	-	25. Was case referred to medical				26. Place of	of Death	1□ Yes (Check only o	_2 XX No one}	1 □ Ye:	s 232 No		
10 B		examiner? 1 Yes No Hospital: 1 🔀	npatient 2 ER/C	Outpatient	3□ DOA Othe	r'		ne 5□Resi		□Other (Spe	ecify)		
Ë.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Monit	of Injury 28b	. Time of Injury	28c. Injury Work	at ?	2	28d. Describe	how injury	occurred			
catic		2 Accident investigation M 1 Yes 2 No											
Certification:		determined 20e, Flace	ng, etc. (Specify)	rarm, stre	ет, тастогу, опісе		2	City or To	wn, State)	Number or H	tural Route Number,		
Medical C		29a. Certifier (Check only one) 1 **X**Certifying Physician: To the bound on the bound of the bound on the bound of the bound on the bound of the bound on the b											
Me		29b. Signature and tills of conflict	Λ		29c. License	number	7,	C.	29d. Date	signed (Mon	th, Day, Year)		
	-	All Hava		\ (T	d) 6	-Cy	+		Ap	ril 15	2008		
		28. Name and address of person who completed caus Shahab Bavan W 31. Date filed (Month, Day, Year) 32. R	e of death (Item 23a 10 1072 Astrar's Signature		ittle Poc	tuxe	nt	Parkw	2y 50	iteaco	Colombia MD 21044		
State strar			Masura D	4	meter			· · · · ·	,				

(3) 02

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			1- For State of Maryland / Dep Registrar Ce	partment of Health and I	Mental Hygie	2000	13933	
	Physic		1. Decedent's Name (First, Middle, Last) Joseph C.	Fenwick	2. Date of Death April 1(Day 2008	3. Time of Death 3:00 P.M	
	/Medi Exami		4a. Facility Name (If not institution, give street and number) Sligo Creek Nursing Home	4b. City, Town, or Location of Death Takoma Park	 -	4c. County of Death Montgomery		
	. Funeral Director		5. Social Security Number 216-44-8884 Usual Residence of Decedent 6. Sex 1 7. Age (In yrs. last birthda) 97 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 12, 1	9. Birthp County 910 Mary	lace (State or Foreign otry) Land	
	Maryland I-f show	ctor	10a. State 10b. County 10c. City, Town or the Maryland Prince George's Adelphi	ocation		1	0d. Inside City Limits 1 ☐ Yes 2 No	
	th with the 23s or 28	Funeral Director	10e. Street and Number 2601 Muskogee Street	10f. Zip Code 20783		Citizen of What Cour ited State		
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example, unal be a puffer at ance.	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces 1 1 No. No. No. No. No. No. No. No. No. No.	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.	
21215-0036	be filed within 72 hours a al Hygiene. d other than "natural; o	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Second (0-12) College (1-4or 5+) Print	edent's Usual Occupation e kind of work done during most of won DO NOT use retired) ITOT	king	o. Kind of Business/Ind Cederal Gov		
Maryland 2	12 should be filed and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) Ignasius Fenwick	Pearl W				
	nd 2 shall and alth and 27 is m			ling Address <i>(Street and Number or Ru</i> Muskogee Street <i>A</i>				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	osition (Name of smallory or other place) Jashington Cemeter		Location - City or To 8 Adelphi,		
Balt	permit. Departr Imports any inj			Johala V. Borgward 400 Powder Mill R			v1 and 20705	
8760,	certificate be executed American and continue by section and continue are the burial-fransit	Ilcal Examiner	23a. Part 1. The disease, or complications that caused the death. Do not enshold, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flag, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death	
P.O. Box 68	certific iding p	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year	
	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the			co use contribute to th		
Il Records,	The ate h page	Completed	malignancy		24a. Was an autopsy performed 1 Tyes 2	prior to con	osy findings available inpletion of cause of 2X No	
of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatie		th (Check only one)	6 ☐Other (Specify		
ion of	Jing J. After fune	Certification; T	27. Manner of Death 1X Natural 5 Pending 2 Accident Accident Services (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	THE SELECT 4 A INDISTING HE	28d. Describe how i		7	
Division	after de Directo	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S.	and Number or Rural ate)	Route Number,	
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury: At home, farm, street, factory, office 28f. Location (Street and Number or in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Mon) 28e. Place of Injury: At home, farm, street, factory, office 28f. Location (Street and Number or in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Mon)								
10		M	29b. Signature and title of certifier 437 2	29c. License number D45471		pril 10, 20		
			30. Name and address of perso who c. pleted cause of death (Item 23a) (Type Yeheyis Negussie, M.D. 1111 Spring S	Print) Street,#214 Silver	Spring, N	Maryland 20)910	
	Sta Reg <u>i</u> str		31. Date filed (Month, Day, Year) APR 1 5 2008 32. Registrar's Signature	antie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kenneth Franklin Filler 11:40P M April 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Frederick Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 T F Yrs. 218-38-1707 Director 75 Sept.12, 1932 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 12217 Woodsboro Pike 21757 by Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M 8 meat cutter wholesale & retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည William H. Filler Rita B. Pittinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Winter Brook Dr. Walkersville, MD 21793 Neil Filler/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haugh's Cemetery 4/21/2008 | Ladiesburg, MD 21. Signatule of Funeral Service I 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending p use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

10200 Coppermine Rd.

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashe

APR 29

Gene

31. Date filed (Month, Day, Year)

D0031058

Woodsboro, MD 21798

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) tountai **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury WICOMICO Hospice 6. Sex 1 M 2 □ F 7. Age (In yrs. [ast birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days MORYLAND Director 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show di al Examiner must be notified at 1 Yes 2 □ No Wicomico Fruitland Directo 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed inthin 72 ho Department of Health and Mental Hygi ne. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, 1 M di al Is 15. Decedent's Education (Specify only highest grade completed) Phillip Perdue Elementary/Secondary (0-12) College (1-4or 5+) FARM Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy KING ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fruitland, P. U. BOX Md (COUSIN) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fruitland, md 4-15-08 Mt. Calvary Umc Cem 917 W. Isabella St. ame and Address of Facility
Bennie Smith
Funeral Home 21. Ignature of Fireral Service Licensee Salisbury and 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner DRSRAS 2 Such nitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 🗚 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes — ☐ No 24a. Was an autopsy page perform 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No Inpatient 2 ER/Outpatient 3 DOA 1 Tes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and till of certifier 29c. License number DO05 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po gox 1733 Stas grape un zizoz HOSPICE GHUMM WARY COASTAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 15

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health an Certificate of Death		2000 10000
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death	. No. 2000 3300
п	Physic		0.1.	Month	Day Year
T A	/Medi Examir		SylVla E. Fidler 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D		4c. County of Death
100	LAGIIII		Courtal Lacour at the Lake Sulishus	4	Wicomico
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		9. Birthplace (State or Foreign
	Director		215-62-0144	Min. (Month, Day, Y 5-26-193	. 37
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
	laryla sho	5	ND		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Maryland a or 28a-f show the notified at	Director	MD Wicomico Salisbury 10e. Street and Number 10f Zin Code	140	
	with a or		000 77 11		. Citizen of What Country?
	eath 1s 23 musi	era	902 Walbash Street 21804 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin		USA 14. Race - American Indian,
"	fter d riten liner	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifiled at	by	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify: White
9	72 ho natur lical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	16	b. Kind of Business/Industry
7	thin le. lan "	혈	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	WORKING	
2	filed with Hygier ther the	ပ်	12 Homemaker		Own Home
P	lid be fil lental H ked ott ic even	a		Name (First, Middle, Ma	iden Surname)
Maryland	2 should be and Menta Is marked aumatic ev	은	Simon Ekrheim Anna		Lunde
Ma	d 2 sl th an 7 Is r traur		19a. Informant's Name/Relationship (Type. Frint) Ronald J. Fidler – husband 902 Walbash Street.		
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Ronald J. Fidler – husband 902 Walbash Street, 20a. Method of Disposition 2 MCramation 3 Deproval from State cemetery, crematory or other place)		MD 21804 c. Location - City or Town, State
ho	Pages nent of int: If its iry or o		The band 2 More mation 3 mile moval from State		•
Baltimore,	# 문학수		4 □ Donation 5 □ Other (Specify)	-15-2008 De	elmar, Delaware
m	Depa Impo any i		Milista Henry Blake 705 E. Main Street	bounas rune: at Saliebur	ral Home Ty, Maryland 21804
			23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	diac or respiratory arrest	Approximate Interval Between
	Physician	11	Immediate Cause (Final	ULMONAR	Onset and Death
a	/Medical		resulting in death) Due to (or as a consequence of):	161-1010171	DRSEASA_
U	Examiner		Sequentially list conditions, b.		
9.0	sit sd	Examiner	il ally, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury		
	xecut and I-tran	хап	resulting in death) Last C. Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		and to for as a consequence of).		
687	ficate phys s the	edical	d		
Box	leath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		23d. Date of delivery
m	ires that the death signed by the atte d be detached for r	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.O.	t the by the	hys	9□Unknown 9□Unknown		
S, F	ss the gned se der	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w require	ed		_ 1 ☐ Yes	2 No 3 Frobably 4 Unknown
ပိုင	e law r has be je 2 sh	Completed		24a. Was an	24b. Were autopsy findings available
<u> </u>	The	Son		— autopsy performer 1∐ Yes 2€	prior to completion of cause of death?
/ita	iclan: Th certificate rector, pag	Be	examiner:	Death (Check only one)	
2	Physic this c	ဥ		g Home 5 ☐ Residenc	e 6 □Other (Specify)
Division or Vital Records,	Jing I	ö	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? April 28c. Injury at Work?	28d. Describe how i	njury occurred
<u>S</u>	or Attending after death. Director: After in by the funer	icat	2	Old Legation (Ctr	
<u>></u>	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, S	t and Number or Rural Route Number, itate)
	To the Hospital or Attending Physician: The la within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 4- Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	lace, and due to the caus	e(s) and manner as stated.
	he Ho in 24 l he Fu pletel	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of one) and manner stated.	occurred at the time, date	and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
)	1.0		D00586	110	4/14/08
	10 Ja		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		^ .
	Sta	10	CHUYAM WARY COASTAL HOSPICA P. BOX 1 31. Date filed (Month, Day, Year) 32. Projecta's Signature	135 SAL	15BULY UD. 21802
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (HUHM WAR'S COASTA HOSPICA POBOX 1 31. Date filed (Month, Day, Year) APR 1 5 2008		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02885 State of Maryland / Department of Health and Mental Hygiene Rella Dee Glover Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day April 12, 2008 Physician/ 2039 hrs ব Examiner <u>Rella Dee Glover</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Dunkirk 275 Greenridge Drive Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex oreign **Funeral** Months Country) Ohio Oct. 22 1955 Director 1 M 2XF 52 215-74-7361 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No Dunkirk Anne Arundel Co. or items 23a or 28a-f shov MDExaminer must be notified at once. 10g. Citizen of What Country? Directo 10f, Zip Code 10e. Street and Number 20754275 Greenridge Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes Specify: White 1 Yes 2 X No specify: If Yes. Give Year Divorced 3 Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 1 and 2 should be filed within 72 item 27 is marked other than "traumatic event, the Medical 21215-0036 Office Furniture (1) Furniture Specialist 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Arrella Jane Johnson</u> Be Richard P. Herdman Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ೭ Maryland 20754 75 Greenridge Drive, Dunkirk, Baltimore, MD (Husband) Glenn Glover 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 2008 crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Pages I Department of I-Clinton, Maryland April 14. rtant: Crematory Donation 5 Other Specify 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fun 3 mpor MD 20736 8125 Southern Maryland Blvd., Owings Michael W. Approximate Interval 23a. Part I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Medical Introral curshot wound Immediate Cause (Final disease *x*aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate ne cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AME#25a, 27, 28a-f, perME, g879, 5/7/08 TI X UNPENDED g physician 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year Day Month Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

The law requires that the death certificate be Box 68760 signed by the attending the detached for use as t Division of Vital Records, P.O. I to Hospital or Attending Physician: The law requires that the 1.24 hours after death.

e Finneral Director: After this certificate has been signed by the etely filled in by the funeral director, page 2 should be detached.

þ

Completed

Be

Certification

3 X Suicide

29a. Certifier 1

Homicide

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death?

performed?

✓ Yes 2

1 🗸 Yes

29d. Date signed (Month, Day, Year)

April 13, 2008

26.Place of Death (Check only one) 25. Was case referred to medical Other; Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 ER/Outpatient 3 2 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28h. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Yes 2 X No Natural Pending 4/12/2008 8:29 pm Accident Investigation

subject shot self 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 275 Greenridge Dr. Dunkirk, MD

(Specify) residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29b. Signature and title of certifier O.C.M.E. m

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD

31. Date filed (Month PR) 32. Registrar's Signature State 2008 MILLE. Registrar

Could not be

To the Host within 24 ho To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jane Lightfoot Guthrie 14, 2008 8:00a April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Friends Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 □ M 2 T F 522-24-2909 92 May 10, 1915 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Montgomery Sandy Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17330 Quaker Lane 20860 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after or ealth and Mental Hygiene. n 27 is marked other than "natural", or iter 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Menta Item 27 is marked William John Lightfoot Florence Holdsworth ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Guthrie/Son 102 Granville Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 14, 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2008 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical the as attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Was a... autopsy performed? page 2 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certificd completely filled in by the funeral director, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient **Æ**¥No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 144Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

15

30. Name and address of perform ho completed cause of death (Item 23a) (Type, Print) Evelyn D. Jackson, MD 3416 Olandwood

2008



3416 Olandwood Court, Olney, MD 20832

MRIL 14, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2008 April **Physician** Robert E. Granick 11, 1:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4450 South Park Avenue #908 Chevy Chase Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 21, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. New York, N.Y. 261-40-2384 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Maryland Montgomery Chevy Chase 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 4450 South Park Avenue, #908 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: WW-II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4orடி்ந் Elementary/Secondary (0-12) Foreign Service Agent Federal Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, if 17. Father's Name (First, Middle, Last)
William Granick 18. Mother's Name (First, Middle, Maiden Surname)
Rose Lieblich Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4450 South Park Ave.,#908 Chevy Chase, Md. 20815 Lois Granick -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gdns. 4/14/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify), 21. Signature of Funeral Servic Licen of Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diabetic Hyperosmolar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Cerebrovascular Disease and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Coronary Artery Disease: Prostate Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy perform certificate 1∐ Yes 20 No or Attending Physician: eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19955 April 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ace Lipson, M.D. 1120 19th Street, N.W., #200 Washington, DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 881 7-3-08 vt. State of Marviand / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** April Cecilia Garner 2008 5:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2195 Crain Highway Charles Waldorf If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🔀 F Months Director 92 APR.26,1915 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts show ir than "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at 1 ☐Yes 2√2 No Director Charles Waldorf 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 2195 Crain Highway S. A. 20601 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ited within 72 hours after 1 ☐ Yes 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. Specify: If Yes, Give Year or Dates: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker At Home Ith and Mental Hyc. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Vivian Cooksey Lucy Jeanette Murphy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Health Rose M. Tedder/Daughter 5667 Huckleberry Dr. Bryantown, MD 20617 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April Pages 1 5 = 6 MBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. St.Paul's Ch.Cem. 25,2008 Waldorf, MD ' 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Raymond Funl. Services, P.A. 21. Signature of Funeral Service Licensee M006415635 Washington Ave.La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRONCHI-ASTHAMATIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? į 4□Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should DISEASE HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No certificate 1 Tyes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ° 1 TYes this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospitel or Attending 5 Pending 1 Natural after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 0 22 744436 Name and address of person who completed cause of death (Item 23a) (Type, Print) Pake 102 PAUL Mellon

DHMH 17 Rev 1/2001

State

Registrar

3 Date filed (Month, Day, Year) APR 2 9 20

9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

13941 State of Maryland / Department of Health and Mental Hygiene 200 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Apr 20, 2008 GROVE **Physician** :31am SUSAN W /Medical 4c. County of Deeth 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) Examiner **Devlin Manor Nursing Home** Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign County) Nate of Birth Mar 1, 1952 5. Social Security Number 214-62-4265 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 KF 56 Director Usual Residence of Decedent 10c. City, Town or Location Cumberland Allegany 10d. Inside City Limits the Maryland 10a State items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? 10f Zio Code 10e. Street and Number 21502 USA 315 Pennsylvania Avenue r death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural; or tile ury or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) McDonald's Rest. cook 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Marie Logue ဥ 199 Holly Michigan Avenue or Rural Route Number, City or Town, State, Zin Code), 1502 19a Informant's Name/Relationship (Type, Print) friend 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of Dete 20a. Method of Disposition St. Mary s Cemetery of other place) 4/23/2008 MD 1 Burial 2 Cremation 3 Removal from State Cumberland permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NamScarpetti Fürreval Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pant. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monic /Medical Due to (or as a consequence of): **Examiner** con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day ō 4 Pregnant at time of deeth 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the funeral director, page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To 1 Yes > No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0062929 04, 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 MEMWRIAL AVENUE #105 EMMANUELS OSET-BOAMAH FUNREY LAND MI) 21503 CUMBERLAND, MD

State Registrar 31. Date filed (Month, Day, Year) APR 2 9 2008 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Sara Veronica Simmons Gootee 4pry 21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, pive street and number, Examiner Kastor 10 ON If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs Months 1 □ M 2 1 F 214-10-0685 87 10/18/1920 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County must be notified at 1 ☐ Yes 2 No Director Maryland Dorchester Church Creek 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 3290 Golden Hill Rd. USA 14. Race - American Indian, Black, White, etc. 21622 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or Items 11. Marital Status the Medical Examiner gges 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examine. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: White Maryland 21215-0036 ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marine Clerical 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caleb Alexander Simmons Mary Cousins ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3287 Golden Hill Rd. Church Creek,MD 21622 Henry Gootee/Son 20b. Place of Disposition (Name of St. Mary Star of the Sea Church Cemetery Baltimore, Date 20a. Method of Disposition Pages 1 XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4/24/2008 Golden Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12400 Physician myour dial /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine fo the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 ☐Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 No 2 ER/Outpatient 3 DOA ٩ 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eglseder. M.D. 503 Cynwood Dr. Easton, MD 21601 Ludwig J. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 Registrar DHMH 17 Rev 1/2001

DHMH I7 HeV I7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended item #7,4/23/08, WCHD Certificate of Death SLU Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Beatrice Gavigan A M /Medical 12 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice At the If Under 24 Hrs. 1) 1comico Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 098-14-9767 Director 1 2/11/1922 New York Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Quantico items 23a or 28a-f shiner must be notified Maryland Wicomico Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6442 Quantico Road 21856 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after do Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any filury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan processor banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Unger Mary Ramsey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Gavigan/son 6442 Quantico Rd., Quantico, MD 21856 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 4/14/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Coensee Name and Address of Facility Holloway Funeral Home Professional Association 16.46 K 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Dav Year 5 Other (specify) ☐Yes 2 No the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No has page 2 autopsy perform certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To after death.
I Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29505 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

CHINABERRY DR., SALISBURY, MD 21801

GREGORIO M. BELLOSO, M.D., 5302

2008

31. Date filed (Month, Day, Year)

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			1. Decedent's Name (First, Middle, Last)					T	2. Date of Dea			3. Time of Death
	Physic /Medi		Marie Rose Harvey	Goguen						Month 4/2	21/2008	Year	9:00 PM
	Exami		4a. Facility Name (If not institution, give	street and number)	4b. City,	Town, or	Location of	f Death		4c. County	of Death	
		. a	William Hill Mano	r				aston			I	albo	t
ľ	Funeral		5. Social Security Number 6. Sec	x 7. A 3 M 2 X F	ge (In yrs. last birthday	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day		9. Birthp	place (State or Foreign
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	land w		10a. State 10b. County		10c. City, Town or L	ocation						- 1	0d. Inside City Limits
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9	after or ite mine		1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2 X If Yes, Give	r No	1 ☐ Yes 2	27.2		, Puerto F	lican, etc.)		k, White,	
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5	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition uring most	of workin	a I	16b. Kind of Bu	siness/In	dustry
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75	illed v Hygie ther 1 nt, th	ပိ	17. Father's Name (First, Middle, Last)		Se	amstr	$\overline{}$	10 Mothor	r'o Namo	/First Adiabata	Manuf Maiden Surnam		ring
ano	d be i	Be	John Harvey									<i>e)</i>	
Maryland 21215-0036	2 should and Mer is marke aumatic	유	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Maili	na Address	(Street a			Harvey	r, City or Town,	State 7in	Cada
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ē,	of ite		20a. Method of Disposition		20b. Place of Dispe	osition (Nam	e of	LIC IN		ite ,	20c. Location -		wn, State
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Baltimore,	permit. Page Department o Important; If any Injury or once,		21. Signature of Funeral Service License		12						PO Box		
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г			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause	d the death. Do not en								Approximate Interval Between Onset and Death
9	Physician		Immediate Cause (Final disease or condition		isquest	con	ra	reun	nn	ua		1	Onset and Death
	/Medical		resulting in death)	Due to (or as	a cons uence of);	A	λ	^	c ,	0	-		1000
	Examiner	_	Sequentially list conditions.		Cerebrov	bsculi	a D	lesare	cl	berne	peren		Team
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):							_	
8760	cate be executed physician and the burial-transit			240 10 (0) 40	a consequence oi).								
687	The law requires that the death certificate be executed tto has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	edical										-	
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	pf pregnancy						23d Date	of delive	n,
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐Pregnant a		⊒Ectopic pre ⊒Other <i>(sp</i> e					Mor		Day Year
л О	tt the by th tache	hys	9 Unknown	9∐Unknown									
	w requires that the d been signed by the should be detached		Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use contr	bute to th	e cause of death?
Hecords,	equir en si ould I	Completed by	De Jakensun	1						1 □ Y	es 2 No	3 🗌 Prob	ably 4 □Unknown
ပ္ပ	law r as be	ple	Distretes Mall	hus			_			24a. Was a		ere auto	osy findings available
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Vital	Physiclan: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	1					of Death	Check only on			
0	this ald	ဥ	1 103 30 110	ospital: 1 ☐ Inpatie				4 Li Nurs			ence 6 DOthe)
	ding I	ioi	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o Injury		c. Injury Work?			d. Describe ho	ow injury occurre	ed	
DIVISION	I or Attending Phys after death. Director; After this I in by the funeral di	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of ini	UN - At home farm etr	M eet factory		es 2 □ No		4 1 1 - (0)			
2	al or Attendir after death. I Director; At d in by the fu	Certification:	4 ☐ Homicide determined	building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, lactory,	Office		26	City or Town	reet and Numbe n, State)	r or Hura	Route Number,
	re Hospital 124 hours a re Funeral I		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge, deat	n occurred a	t the time	a, date and	Dlace, ar	nd due to the c	ause(s) and ma	ner as st	ated
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 ☐ Medical Examir one)	er: On the basis o and manner st	r examination and/or in	vestigation,	in my op	inion, death	h occurre	d at the time, d	late and place, a	nd due to	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	. 1 1	00	29c.	License			2	9d. Date signed	(Month, I	Day, Year)
			William	HWO	ed Mis		126	158	15		4/21	-108	
			30. Name and address of person who con	npleted cause of d	eath (tem 23a) (Type,	Print)							
			William H. Wood,Jr.	,M.D. 28	474 Kings I	Woods_	Dr.	Easto	on, M	21601			
4	Sta Registra		31. Date filed (Month, Day, Year) APR 2 9 2008	32. Registr	ar's Signature	a0 2"							
			BLD 0 0 /100	/ 176 A A A A	Alle Allendon	and an							

The state of

			1 = For State Registrar		f Maryland / I		rtmen			and M		Reg	ene . No. 2 (08	13945
	Physic /Medi		1. Decedent's Name (First, Middle, Gladys M.	,							2. Date of Month A pril		^{Day} 2008	Year	3. Time of Death 5:30a M
1	Exami		4a. Facility Name (If not institution,		•		4b. City,	Town, or	Location o	f Death			4c. County	of Death	
			Heritage Harbour				16111		apolis				Ann		undel
2	Funeral Director		118-14-8302	3. Sex 1 □ M 2 120 F	7. Age (In yrs. last bi 90yrs	Yrs.	If Under Months		If Under : Hours	Min.	8. Date of (Month,	Day, Y	^{'ear)}	Cour	lace (State or Foreign htry) th Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	eation								
	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	ō		Georges'		VII OI LOC	Jalion							'	0d. Inside City Limits 1 Yes 2 No
		Director	10e, Street and Number	Georges	Bowie	-	10f. Zip	Code				100	. Citizen of W	/hat Cour	
	3a or	٥	7600 Laurel Bow	rie Rd.				0715				108	U.S.A		
	death ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. W				gin? (Spe	ecify Yes or Rican, etc.)	No-			an Indian,
9	ours after c ral", or iter Examiner		1 X Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Giv			Yes, spec		n, Mexican Specify:	, Puerto	Rican, etc.)			k, White, . B1 a	
003	ıral", I Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites:	'	Lifes 2	21 <u>-</u> 1110	Зреспу.				Specify		
21215-0036	n 72 hours "natural", edical Exa	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	. Decede (Give k	ent's Usua kind of wor O NOT us	al Occupa k done d	ition uring most	of worki	ing	16	b. Kind of Bu	siness/Ind	dustry
12	within ene. than " he Mec	Ę.	Elementary/Secondary (0-12) 8th grade	College (1-	-4or 5+)	_	erer	e reurea)					Self E	mn 1 o	vad
d 2	be filed within tal Hygiene. Id other than event, the Mevent	Be C	17. Father's Name (First, Middle, La	ast)					18. Mothe	r's Name	(First, Mide		iden Surnam		yeu
lan	fenta rked rlc ev	To B	Neverson Hunter	, Jr.					Je	nnie	: Than	p			
Maryland	ges 1 and 2 should be to for Health and Mental I if item 27 is marked or or other traumatic eve	Г	19a. Informant's Name/Relationship	(Type. Print)	195	o. Mailing	g Address	(Street a	nd Numbe	r or Rura	al Route Nu	mber, C	City or Town,	State, Zip	Code)
	0 ± 1 = 0		E. Louise White	, Niece	109	910	Exete	er Co	ourt,	Larg	o, Md	207	774		
Baltimore,	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	XRemoval from S	20b. Place of comete Rock (f Dispos	ition (Name	ne of ther place	2	4 – 12	ate		c. Location -		,
tim	permit. Page Department of Important; If any injury of once,		4 □ Donation 5 □ Other (Spe	ecify)	ROCK				_				shingt		
Bal	Depar mpor mpor any in		21. Signature of Funeral Service Liv	censee 4											ce, Inc.
			23a Part Enter the disease or or	molifortions that as	used the deeth. De								ington	, DC	
	**-		23a. Part f. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final									y arres	3		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Seve	ere periph or as a consequence	eral	l vas	cula	r dis	ease	2			_	
	Examiner				rene left		ot								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
	certificate be executed Iding physician and Ise as the burial-transit	Examiner													
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ğ	death e atten	iciar	in the past 12 months?	1 Live bi	rth 2 ☐ Fetal death ant at time of death		Ectopic pre Other <i>(spe</i>						Mor	e of delive nth	ny Day Year
P.0	t the by the ache	hys	9 ☐ Unknown	9□Unkno	wn	_									
	law requires that the di as been signed by the 2 should be detached	by P	Part II. Other significant conditions	s contributing to dea	ath but not resulting in	n the und	derlying ca	ause give	n in Part I.		23e. Di	d tobac	co use contri	bute to th	e cause of death?
ord	equir	ed									1 [Yes	2 X] No	3 ☐ Prob	ably 4 ☐Unknown
Records,	2 88 2	Completed									24a. W	as an	24b. W	ere autop	osy findings available npletion of cause of
_	T after T	Sol									1□ Ye	erforme	d? d No 1	eath?	2 □ No
Vital	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				0		of Death	(Check onl	y one)			
ō	Phys rthis ral dir	2	1 ☐ Yes 2 📉 No 27. Manner of Death	1 ☐ In	patient 2 ER/Ou	tpatient Time of			4 A I Nur				e 6 □Othe		′)
Ou	Attending Physician: r death, ector: After this certifics by the funeral director, i	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month		nAvry	M Z	3c. Injury Work? 1 □ Y	ai es 2 <mark>X</mark> in		zaa. Describ	now N/A	injury occurre	€a	
Division or	l or Attend after death. Director: /	Certification:	3 Suicide 6 Could not	ho	of injury - At home, fa g, etc. (Specify)	rm, stre			20.		28f. Location		_	er or Rura	l Route Number,
Ö	s after	FIT	4 Homicide determine	buildin	g, etc. (Specify)						City or	Tòwn, S	State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical ((Check only 2 Medical Ex	aminer: On the bas	pest of my knowledge sis of examination an	e, death	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to to ed at the tim	he caus	se(s) and mar	ner as st	ated.
	thin 2 the or the	Med	one) 29b. Signature and title of certifier	and manne	er stated.			License							
) .	⊢ ≽ <u>⊢</u> 8		· Oon.	you				0405					Date signed / 10/08		Juy, 1001/
1	0	-	30. Name and address of person wh	o completed cause	of death (Item 22a) (Type P									
			Mirza Nussaree 7	•	, , ,		,	en R	urnie	мт	2106	1			
4 2	Sta	le	31. Date filed (Month, Day, Year)		gistrar's Signature		, 01			9 LAL	2100				
T 186	Registr	ar	APR 1 5 20	108	150 B 1	1004	60								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No.C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year 6:00 PM Edith Sanelma Hagelberg April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12960 Little Hayden Circle Hagerstown Washington county 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country)
New York **Funeral** 1 □ M 2 1 F Days 91 076-58-2532 Director Sept. 28,1916 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12960 Little Hayden Circle U.S.A. 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: White þ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Tang 2 shours.
Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.

Department of Health and Mental Hygien.

Important: if item 27 is marked other the any injury or other traumatic event, It all once. Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be |Alarik Tattala Matilda Kosola Tattala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Hagelberg, Sr.-son 12960 Little Hayden Cr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4-19-08 Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Yea Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

28a-f show

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

the burial-tran

hed by the attending physician detached for use as the buria Completed Be

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural

Certification: To 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. signed by Division of Vital Records, certificate has been signirector, page 2 should be To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

WH-7

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

28c. Injury at Work?

1 □Yes 2 □ No

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

autopsy performe 1 ☐Yes → No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

280 MORTHERN 31. Date filed (Month, Day, Year)

1 ☐ Yes 2 📉 No

2 Accident 3 Suicide

4 Homicide

(Check only one)

APR 18 2008

5 Pending investigation

6 ☐ Could not be



ORIGINAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐Yes 2 ☐No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 14^{Day} 2008 ear **Physician** 9:25A. M Fmma Ingram /Medical 4a. Facility Name *(If not institution, give street and number)* Hillhøven Assisted Lvg. Nursing & Rehøb Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Adelphi Prince George's 5. Social Security Number 579-22-7971 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Days Hours Min. 88 Georgia 1 □ M 2X□ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Maryland Prince George's College Park Directo 10g. Citizen of What Country? 10e. Street and Number 8315 Potomac Avenue 10f. Zip Code 20740 United States filed within 72 hours after death w Hygiene. Ither than "natural", or items 238 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager's Assistant Furniture Retail and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event, once. Ollie Lanier John Weslev Wilev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynn E. Ingram -husband 8315 Potomac Avenue College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4/19/2008 Silver Spring, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral S. rvine Licen see Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭ11 Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pre Renal Azotemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 1☐Live birth 2 Fetal death 3 Ectopic pregnancy for Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Dementia 3 Probably 4 ∭Unknown 1 ☐ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No page 2 certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ hours after death.

Ineral Director: After this

y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the within 2. one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51897 April 14, 2008

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 5 2008

30. Name and address of person who completed cause of death)(Item 23a) (Type, Print) Njideka Udochi, M.D. 9055 Chevrolet Drive,#100 Ellicott City, Maryland 21042

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8880 6-19-08vt. State of Marylane? Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Joan Johnson-Biefeld 2. Date of Death 3. Time of Death Teresa Day Month 2008 7:20 A M April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5651 Cherry Street St. Leonard Calvert If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2₩F 220-58-8798 55 09 - 29 - 1952Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 440 Council Bluffs Court 20657 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 💆 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) violinist music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregory Hartmann Harriet Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Langley, friend 5651 Cherry Street, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04-05-08 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain Tumor disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. E. list Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) pf pregnancy 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) time of death ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performe 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 I Nursin riend's er of Death sidence 5 Pending investigation Jatural.

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certific

Division or Vital Records, P.O. Box 68760,

dical E	
nysician/Me	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow
eted by Phy	Part II. Other sign
Completed	
To Be	25. Was case refe examiner? 1 ☐ Yes 2∑
ification:	27. Manner of Dea 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

Za I		d
r i y si ciali / mieul	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown
2	Part II. Other significant conditions	s contributing to death bu
ישובונים		
	25. Was case referred to medical	
3	examiner?	Hospital:

6 ☐ Could not be

pital:	1 🗆 I	npatient	2 🗆	ER/O	utpatient	3 🗆	D	OA	
28a.	Date (of Injury th, Day Ye	ear)	28b.	Time of Injury	М		28c.	
						EV8	-		

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.

				7	I I I MUI SIII (ż
28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c.	Injury at Work?		
		М		1 ☐ Yes	2 No	
28e. Place of injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, of	ffice		

me	5 ☐ Res	idend	e 6	Other :	(Specify)	İ	
28d.	Describe	how	injury	occurred	r	·e	5

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Certifying Physi	cian: To the best of my knowledge, death occurred at the time, da	ate and place, and due to the ca	ause(s) and manner as stated.
2 Medical Examine	er: On the basis of examination and/or investigation, in my opinion	in death occurred at the time d	ate and place, and due to the causely

29b.	Signature	and	title	of	cert	ifie
					-	

29a. Certifier

(Check only one)

29c. License number

ince Freduick MD

29d. Date signed (Month, Day, Year)

CENT		
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¥	Dogio	

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 10, Glorious E. Johnson 2008 14:48 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Jan. 14, 1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 579-34-8064 84 1 ☐ M 2 💢 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location "natural", or Items 23a or 28a-f show dioal Examiner must be notified at 1 ☐ Yes 2 → No Hillsborough Ruskin Florida **Funeral Director** 10g. Citizen of What Country?
United States 308 7th Avenue, N.W. 10f. Zip Code 33570-3538 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail Grocery 18. Mother's Name (First, Middle, Maiden Surname) Lillian Mae Bladen 17. Father's Name (First, Middle, Last)
Joseph A. Phelps Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3320 Kilkenny Street Silver Spring, Maryland 20904 Iona C. Flynn -sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 4/14/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner YUNCUY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an OU page 2 s autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gravino, 10313 egistrar's Signature 31. Date filed (Month, Day, Year) 32 State APR 1 5 2008 Registrar

Registrar

State

Smith, MD / 400 West Seventh St./ Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registr s Signature

LaMont

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician APRI HARLO 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMER GENERAL MONTGOMER HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) **Funeral** Dec. 16 ,1922 Months Days Min. Country) New 1 ☐ M 2 ☐ X 85 Jersey Director 088-12-4861 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7.7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its fielded Exactor must be notified. 1 ☐ Yes 2 ☑ No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 72 hours after death with 20906 U.S.A. 15101 Interlachen Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Brands and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tobacco Account Payable ⊥2th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Marion Sheppard Willis Fleming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trains 100-18 Dekruif Pi, #18C, Bronx, NY 10475 Thomas Kirkland (Son) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 Removal from State 4/21/08 Calverton Nat'l Cem Calverton, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 246 N. Washington St, Rockville, MD 20850 23a. Part I. Enter the diseast, or complication that caused the shock, or heart failure. List only one cause on each line. or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** SYSTOL /Medical Due to (or as a consequence of): Examiner MYOCARDI Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit ORONARY Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyrer of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

State Registra

ADEWUNM 31. Date filed (Month, Day,

29b. Signature and title of certifier

2008

Sawannz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Kenstavicius April 11 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3406 Cherry Hill Court Beltsville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth June 16, 1912 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔽 F 327-30-0200 95 Li thuania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show be notified at 10d. Inside City Limits Maryland Prince George's Beltsville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 20705 10g. Citizen of What Country? United States "natural", or items 23a or edical Examiner must be 3406 Cherry Hill Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 245 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 No 2 Specify: Specify: White 3€ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Liemant Ona (unk) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mirga Massey -daughter 10503 46th Avenue Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/12/2008 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Circenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 years Concestive Heart Failure /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Heart Disease 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE nse s 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2€ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 TYes *2***X** No မ After this 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

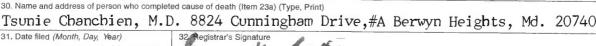
31. Date filed (Month, Day, Year) 1 5 2008 APR

29b. Signature and title of certifier

29a. Certifier

(Check only one)

cal





Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D13339

29c. License number

29d. Date signed (Month, Day, Year)

April 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🛴 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:15 April 10 2008 Helen Joan Kearney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laure1 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F June 25, 1929 78 Director 042-24-2775 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; if item any Injury or other traumatic event; if ite Medical Examiner must be notified at 1 ☐ Yes 2 X No Director **Maryland** Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 3116 Gracefield Road, #VP-T03 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 X No f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: þ 3 ▼ Widowed 4 □ Divorced Year or Dates: Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library Employee Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Christine Kapusy James Joseph Gaffney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4339 Clagett Road, University Park, Maryland 20872 Stephen Kearney - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova! from State 04/18/2008 Fort Lincoln Crematory Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 days Pneumonia /Medical Due to (or as a consequence of): Examiner 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Septicemia Secondary to Pneumonia</u> Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant led by the atten detached for u 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 X No Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown End Stage Renal Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 □ No 1☐ Yes 2K No 1 ☐ Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After Certification: Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mana D59524 April 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen J. Puthumana, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 15 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Departme	ent of Health and Me a <i>te of Death</i>		0000 10051						
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N 2. Date of Death	3. Time of Death						
	Physicia /Medic		Nicholas E. Litsas			9 2008 1012 M						
	Examin			ity, Town, or Location of Death	4	C. County of Death Wicmic						
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un		B. Date of Birth	Birthplace (State or Foreign						
3	Funeral Director		017-07-9493 POM 2□F 89 Yrs. Month		Month, Day, Yea Apr 17,1	918 MA						
546	pu.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
0	Maryla f shoved at	or	MD Worcester Ocean City	,		1 ☐ Yes 2X No						
27	r 28a-	Director		Zip Code	10g. 0	Citizen of What Country?						
	th witl 23a o ust be	ral D	416 Bayshore Dr.	21842		JSA						
2	er dea items ner m	Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.						
38	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	s XXNo Specify:		Specify: White						
215-0036	72 hou natura Jical E	Completed	15. Decedent's Education 16a. Decedent's L (Specify only highest grade completed) (Give kind of	Jsual Occupation work done during most of working T use retired)	16b.	Kind of Business/Industry						
₹.	vithin and the lithan "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	al Advisor		elf-Employed						
d 2		Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (
da Le		To B	Evangelos Litsas	Fotine	Economo)						
Vichel Maryland	2 s ar au	ľ	Tod. Information to the state of the state o	ress (Street and Number or Rural								
-	is 1 and of Health item 27 other to		20a Mathad of Disposition 20b, Place of Disposition (shore Dr., Oc		Location - City or Town, State						
JO.	permit. Page Department o Important: If any injury or once.		Warrial 2 ☐ Cremation 3 ☐ Removal from State	1	14.2008	Fairfax. VA						
Baltimore,			4 Donation 5 Other (Specify) Fairfax Mem. Park Apr 14,2008 Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Mem. Funeral Home									
ω				Braddock Rd.								
200			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death									
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)									
B	Examiner		Due to (of the consequence of).									
	e e	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as *consequence of):									
	ecute and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	Jular	1201							
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9	as as	ledical										
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	he de	ysic	1 ☐ Pes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	r (specify)								
٠ <u>.</u>	s that the ned by detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
spi	equires en sig				1 Tes	2 No 3 Probably 4 Unknown						
၁၁ခ	law re las be	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
<u>e</u>	t The				performed 1□ Yes 2 🔣							
Vit.	slcian certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	Othor	26. Place of Death (Check onloone ther: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
JO C	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		8d. Describe how injury occurred							
Division or Vital Records, P.O	To the Hospital or Attending Physician; The law requires that the death certif within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident investigation M	1 ☐ Yes 2 ☐ No	201 1 1 (01	for d North and a Double North as						
i <u>X</u>	or Att	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	City or Town, S.	t and Number or Rural Route Number, tate)						
	e(s) and manner as stated.											
	he Ho in 24 t he Fu pletel)		and place, and due to the cause(s)									
	To t To t	Medical	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	032212		1/1/08						
				d. 21801								
		ate	Stephen Keim 100 E. Carrol St. SHisbury M. 31. Date filed (Month, Day, Year) APR 15 2008 32 Registrar's Signature	6								
	Regist	rar	MIN TO COOL BUTTONES BY THE									

Romalis Nathaniel Lassiter

2008 13955

		1- For State Certificate of Death Reg. No.													
Physici		Registrar 1. Decedent's Name (First, Middle,Last)									Marth Day Vans				e of Death
edical Exami	ner	Romalis Nathaniel Lassiter									April 6, 2008 1322				22 hrs
28		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De											ounty of D		
		8850 Hampton Par	k Boulevard	l North	Capitol F	~					ice Geo	~			
Funeral		5. Social Security Number	6. Sex	7. Age ((In yrs. last b	oirthday)	If Under 1	_	f Under 2 Hours	$\overline{}$	8. Date of Bi	rth(MM/DD	YYYY) 9	. Birthplace	(State or
Director		225-92-8332	5-92-8332 1XM 2 F 55 Yrs							Min.	in. 7/30/1952 Country)			shington	
											- 7 - 7				1.c.
any		10a. State 10b. County 10c. City, Town of Education												nside City Limits	
* .		D.C.			Wachi	ington								1 X	Yes 2 No
/ // Aaryland 28a-f show 1 at once.	tor				Wasiii	Ingcon	10f. Zip Coo	10				10a. Citizer	of What	Country?	
Mary 28a dat	Director	10e. Street and Number					101. Zip Co.	10		log. Onizon of What Goundy.					
th the Maryland 23a or 28a-f sho		3408 Ely Plac	e S.E.			20019					United States ify Yes or No- 14. Race - American Indian, Black,				
ms 2.	Funeral	11. Marital Status		Was Decedent E Armed Forces?	ver in U.S.		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar								dian, Black,
ni se de l	Š	1 Never Married 2	1	Yes 2X	No		_								
after all', o	by F	3 Widowed 4	Divorced If Yes	s, Give Year ates:			Yes 2 X						ecify: B		
hours after atter	D D	15. Decedent's Education	Specify only hig	ghest grade comp	leted) 16	a. Decedent	's Usual Occ ost of working					16b. Kin	d of Busin	ess/Industr	У
n "n af Ey	Completed	Elementary/Secondary (0	-12) (College (1-4 or 5-	+)	duning	,000	,			,				
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5-0036 led within 72 Hygiene. other than '	ပ္ပ	17. Father's Name (First, Mi	ddle, Last)					18.	Mother's	Name (First, Middle	, Maiden Su	ımame)		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Raymond Nath	niel La	assiter				V	ivia	n M	oore				
21 Duld I Mer i mar	ို	19a. Informant's Name/Rela	tionship (Type,	Print)	i i	19b. Mailing									Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. and 77 is marked other than "natural", or items 23a or 28a-f she umarite event, the Medical Examiner must be notified at once		Marjorie E. I	Lassite	r / Wife	(3408 E	ly P1	ace	S.E.	Wa	shingt	on, D	.C.	<u> 20019</u>	
e, P Land Healt item		20a. Method of Disposition				ce of Disposi matory or oth	ition (Name o	of cemet	tery,		Date	20c. Lo	cation - C	ity or Town,	, State
nor nt of t: If		1 Burial 2 Cren		temoval from Stat	.0	rrecti				/. / 1	6/2008	C1 i	nton	Mar	vland
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Oth 21. Signature of Funeral Se			ikesui	22. N	ame and Ad	dress of	Facility	ODE	Funer	al Ho	mes.	P. A.	, Luna
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other injury or other traumatic event, the Medinjury or other traumatic event,		(XI PIV	All	1X) 13							Forest				47
	ш	23a Part I. Enter the diseas	e. or complicati	ons that caused t	he death. Do	o not enter th	ne mode of d	ying, su	ch as ca	rdiac or	respiratory a	rrest, shock	, or heart	App	proximate Interva
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Phonocycliding (PCP) and coccaine intoxication complicated by drowning Death													
*xamine		Immediate Cause (Final disease or condition resulting in death) a Phencyclidine (PCP) and cocaine intoxication complicated br drowning Due to (or as a consequence of):													
			b Due	to (or as a consci	querioc or).										
	ē	Sequentially list conditions if any, leading to immediate	Due	to (or as a conse	quence of):										
	ni.	cause. Enter Underlying Cause													
d Sit	Examiner	events resulting in death) Last Due to (or as a consequence of):													
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) oe exi ician urial	/Medical	X UNPENDED	L AL	# 555 ,27,28	a-f, p∈	erME, G	379 , 5/7	7/08	TT						
68760, certificate be nding physicise as the buri] §	IF FEMALE: 23b. Was decedent pregnar		3c. If yes, outcom		ncy		0	T-1				Date of d	elivery Da y	Year
68 ertifi ding	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)										World Day			
Box 687 death certific the attending p	Sic	1 Yes 2 No 9	Unknown 9	= -		. 5 Ot	her (Specii)	,							
— # # # # # # # # # # # # # # # # # # #	ı -	Part II. Other significant of			but not resu	ulting in the u	underlying ca	use giv	en in Par	rt I.	23e. Die	tobacco u	se contrib	ute to the c	ause of death?
rds, P.O. B rrequires that the d been signed by the should be detached	<u>چ</u>										1 🔲 🖰	res 2	No 3	Probably	4 🗸 Unknown
S, I uires uires Id be	ed										24a. W	as an	I 24b. W	ere autops	y findings availab
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Recc The lay icate ha	Completed										1 ✓ Ye			✓ Yes	2 No
tal Recision: The certificate	Ü		edical				26			Check	only one)				
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ing Phy After th	-	27. Manner of Death		28a. Date of Inju (Month, Day,Y	ry 2	28b. Time of	Injury 28	c. Injury	at Work	?	28d. Descri	e how inju	ry occurre	d	
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Sicion Atter		2 Accident	Investigation	28e. Place of In				ffice bui	ilding, et	c.	28f. Locatio	n (Street ar	nd Numbe	r or Rural F	Route Number, Ci
Division To the Hospital or Attendividin 24 hours after death. To the Funeral Director: A	Certification	3 Suicide 6 X	Could not be determined		ound ba					- 4	8850 Hampton Park Blvd. Capitol Heis				
nou non	5	29a Geriller	District Control	To the best of my			rred at the ti	me date	e and nla						
he H in 24 he Fu	3	(Check only 1 Certify one) 2 Medic	ıng P nys ıcıan: ıl Examiner:On	the basis of exar	y knowledge mination and	d/or investiga	ation, in my o	pinion,	death oc	curred a	at the time, d	ate and pla	ce, and du	ie to the ca	use(s)
To the Ho within 24 b To the Fu	Medical	20h Signatura and title of	and	d manner stated.					number					d (Month, i	
	2	29b. Signature and title of	-er uner	4	7			0.C.M					7, 200		
		Calno	n	1	1 2	,		U.U.IV	1			April	1,200		
		30. Name and address of				23a)				40.0	004				
		Zabiullah Ali, M.E	. Assista	nt Medical Ex			nn Street	Baltir	nore, l	VIU 21	201				
	Stat	31. Date filed (Month, Day	Year)	32. Registra	r's Signature	head									
Regi	Stra	APR 2 2	7000	A STATE OF THE PARTY OF THE PAR	1	7	2.5								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Catherine Veronica Mevers April 2008 7:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 231 Plum Point Road Calvert Huntingtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-13-1923 9. Birthplace (State or Foreign **Funeral** Months Days Hours 579-20-6856 84 Director Wash., D.C. Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 → No Director MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 72 hours after death with 231 Plum Point Road 20639 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed by Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) hairdresser, salon owner beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. ၉ John Aloysious E11en Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie A. Meyers, Sr., son 4401 Kings Road, St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 04-10-2008 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE HEART Immediate Cause (Final CONGESTIVE **Physician** セト disease or condition resulting in death) /Medical Due to (or as a consequence of) DISEASE ARTERY Examiner CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-tra death certificate be execu Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as 1 . esn IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 moves 1 Ves 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISE 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 OBSTRUCTIVE DISEASC CHRONIC 1 Tes 2 NO 3 Probably 4 Unknown Completed TIMOUFFICIENC CHRONIC 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No performed certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) other: 4 ☐ Nursing Home 5 Desidence 6 ☐ Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Plosp.

RD. PRINCE FREDERICK MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

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32. Registra/s Signature

MUNSHI

APR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Jean Eleanor McNelis April 7. 2008 7:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11450 Asbury Circle, Apt. #132 Solomons 5 Calvert If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) April 25, 1925 Birthplace (State or Foreign Country) 1 □ M 2 🕅 F 578-44-7203 82 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 📉 No Maryland Calvert Solomons 5 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Apt. #132 20688 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Charles Strohecker Louise Hisle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Ralph McNelis / Husband 11450 Asbury Circle, Apt. #132, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Washington National Cemetery 04/11/2008 | Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. th P.O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or Jerry of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 🗌 Yes 2 No 1∐ Yes 2**X** No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show notified at show

the Medical Examiner must be

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23a

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Department of Health a Important: If Item 27 Is any Injury or other tra.

Pages

death

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division or Vital Records,

Director

Funeral

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Completed

Be

and burialphysician the as attending p has page 2 certificate

Physician/Medical

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Completed

Be

Certification: To

Medical

that the death certificate be executed this After Hospital or Attending 124 hours after death.

The Funeral Director: A pletely filled in by the fi

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the I within 2.

State Registrar

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Tardio, MD 14090 Solomons Island Rd., Suite 2500, Solomons, MD 20688

APR

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registra Signature 2008

land MD

29c. License number

D47610

29d. Date signed (Month, Day, Year)

April 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 13, ^{Day} 2008 **Physician** Dorothy Jean Burke McFadden 12:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) 31 Tennessee 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Months Days Hours Min 413-48-7210 Director 76 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or ? 2701 Martello Drive 20904 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Music Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Leonard Burke, Sr. Ida Mae Jenkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charise Hoge/daughter 5005 Randall Lane Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chesapeake Crematory | 04/15/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days a Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uneque or inju.) that initiated events resulting in death) Last Due to (or as a consequence of) Examine be exec Due to (or as a consequence of) Physician/Medical attending I 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acidosis, coagulopathy, hypotension, renal failure 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient ည 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury e Hospital or Attendir 24 hours after death. e Funeral Director: A letely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D60117 April 14, 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036

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FACUEN Division of

> State Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2008

32. Pagistrar's Signal

32. Rygistrar's Signature

Eric J. Park, M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760 attending physician the use as the

Physician/Medical Examiner

Completed by

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Certification: To

Medical

Physician

/Medical

Examiner

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1: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Pages 1

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

After this certificate has been signed by funeral director, page 2 should be detact hours after deathuneral Director: filled in by the 24 hours a

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifier

3 ☐ Suicide

28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number

1 🗀 Yes

2 🗌 No

29d. Date signed (Month, Day, Year)

4-10-2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suparich f8m

HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

State Registrar 31. Date filed (Month, Day, Year) APR 1 5 2008

5 Pending investigation

6 Could not be determined



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/Medical Examiner The law requires that the death certificate be executed burial-Division or Vital Records, P.O. Box 68760. the attending ph signed I page 2 s Hospital or Attending Physician: director

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Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Examine Physician/Medical Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ceel Ws 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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32. pegistrar's Signature

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear 6.25am **Physician** April 14 2008 E1ma Natali /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick 13432 Reed Road Thurmont If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F 22. 198-32-3908 96 June 1911 Pennsylvania Director Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 10a State 10b County a or 28a-f show be notified at 1 ☐Yes 2 No Director Thurmont Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a c United States 21788 13432 Reed Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify. Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giustina Piearacci Giovanni Dolfi ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 I Thurmont, Maryland 21788 Linda McCauley / Daughter 13432 Reed Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or oth April 17 Monongahela, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Monongahela Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Thurmont, Maryland 21788 104 E. Main Street 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDI minutes INFARCTION disease or condition resulting in death) Due to (or as a consequence of): ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HYPER LIPID EMIA Due to (or as a consequence of): by Physician/Medical Completed Be

Physician /Medical Examiner

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Pages 1 and 2 should be filed within 72 hours after death with

Health and Mental Hygiene.

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Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be execute and physician this in by the funeral after death. within 24 hours a

To the Funeral C

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Certification:

Medical

29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year									
Part II. Other significant conditions	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to th	e cause of death?				
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HY PERTENSI	HTO9PH, NO	YROLDISM		performed 1 Yes 2 1		2□ No				
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examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Specify	y)				
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3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,				
29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as s and place, and due to	lated. the cause(s)				

State Registrar

- Hussan

29c. License number D46861 29d. Date signed (Month, Day, Year) 4/14/08.

30. Name in address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE FREDBRICK MD 21702 USSAIN A

32. Registr s Signature 31. Date filed (Month, Day, Year) 2008 APR 15

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Amend 19b, per FD, drw, 4/11/0 8 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10e, per FD, State of Maryland / Department of Health and Mental Hygiene 2 0 8 3 9 150, CCHI 1 8 10 10 10 10 10 10 10 10 10 10 10 10 10													
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IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery													
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The state of Death 26. Place of Death Check only one 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 26. Place of Death Check only one 1 Yes 2 No 27. Manner of Death 28a Date of Injury 28h Time of 38c Injury 38d December 28d December 38d De													
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28d. Describe how i													
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27. Manner of Death 1													
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0065918 29d. Date signed (Month, Day, Year)													
delw 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tim Sein, no 2434 West Belvedere Avenue, Baltimore, no 2/2/5													
State Registrar 31. Date filed (Month, Day, Year) APR 8 2008 State APR 8 2008													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Day Jack F. 7:15 P Patterson 9 /Medical April 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5801 Goldsboro Road Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Hours Director 532-03-1842 93 Feb. 8, 1915 Oregon Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 X Yes 2 □ No Director Florida Sarasota Sarasota 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. or items 23a 220 Bird Key Bird 34236 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. XYes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ White 3K Widowed 4 □ Divorced Specify: Year or Dates: 'natural" WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Newspaper Executive Newspaper Business marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ormand Melville Patterson ပ Lucile Estelle LeRoux 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Department of Health a Important: If Item 27 is any injury or other tra James John Patterson/Son 5519 Alta Vista Rd. Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 1 Burial 2 □ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Silver Spring, MD 2008 21. Signature of Fineral Service Licer 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Melanoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed? 1 Yes 2X No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Klother (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA

Hospital or Attending Physician: this funeral After

the 24 hours after death e Funeral Director: filled in by

27. Manner of Death

To the within 2

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 X Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

MD0052297

28d. Describe how injury occurred

April 10, 2008

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Collin Cullen, MD 7625 Wisconsin Ave. Bethesda, MD 20814

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 15 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008^{Year} **Physician** JOSEPH LEON PAJROWSKI April 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 18804 Cross Country Lane Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5,1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 221-16-5416 79 Sept. Delaware Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglener and straint Hyglener and straint and straint Hyglener than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director 0xford PA Chester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 19363 223 Oxford Road Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: ^{2□}NWWII 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Corp. Forklift Operator 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria Retkowski John Pajrowski ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, MD 20879 18804 Cross Country Lane Mary Barnett (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of Important: If It any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oxford Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Oxford, PA 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 K Other (Specify/Residence Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, hin 24 hours a the Funeral [within To the 2

Medical

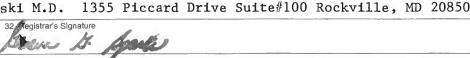
State

Registrar

one)

29b. Signature and title of certifier

Genevieve Wroblewski M.D. 31. Date filed (Month Pay, Year) 2008



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D64615

29d. Date signed (Month, Day, Year)

April 11, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** David Richard Peck 15, 2008 7:15A.M. APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeder's Memorial Home Washington Boonsboro 8. Date of Birth (Month, Pay, Year) April 1 1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 69 Months Hours Min. M 2□F Country, MD 214-76-8681 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov MD Washington Clear Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 11644 Big Pool Road 21722 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. n 27 is marked other than "natural", or ite 1 Never Married Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: spewihite 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) personal College (1-4or 5+) Elementary/Secondary (0-12) Homemaker residence 1st grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel August Peck Rose Ellen Murray ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E.Peck brother 12570 Indian Springs Road Clear Spring,MD item 27 i 20b. Place of Disposition (Name of place) 20a Method of Disposition 20c. Location - City or Town, State Apriff 18 permit. Pages
Department of I
Important: If it
any Injury or o Shanktown Cem. jo Big Pool, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, 23a. P. III. Enter the dise ase, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Course (Fire!) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carcinone Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Ceren Varalu Acadent 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 perform certificate 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 4 No Other: 4 Housing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natiural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18019 APRIL 15, 2008 pote mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a5+6-1 DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740
31. Date filed (Month, Day, Year) | 32. Registrar's Signature

State

Registrar DHMH 17 Rev 1/2001 APR 1 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2008 Year now 3:560 M /Medical April Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death COYPII PSP [7] (2m2) wesmins 5. Social Security Number **Funeral** 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Director 577-03-5112 May 6, Italy Usual Residence of Decedent the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 10g. Citizen of What Country? 2514 Vance Dr. permit. Pages 1 and 2 should be filed within 72 hours after death to Dispartment of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or Health and Hyging or other trainmetin. Funeral 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 budget analyst Federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giuseppe Pirrone Amelia Casalegge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Pirrone/ son 2514 Vance_Dr. Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specificantombment Gate of Heaven Cem. 4/23/2008 | Silver Spring, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service-Lic athanne 11802 Liberty Rd. Libertytown, MD 21762 23a. Part T. Enter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) Days /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed ician and burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 1 ☐ Yes Month 5 ☐ Other (specify) Day Year cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Certification: To 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death To the Funeral Director: filled in by the 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005994 131 2008 30. Name and address person who empleted cause of death (Item 23a) (Type, Print) 295 SPNEVAR westminster

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 2 9

ORIGINAL

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nelson Hugh Rucker 04/09/2008 1:25 p /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Nursing Center Prince Frederick Calvert 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1X M 2□ F Months Hours **61723**1**19**29 Director 220-22-2884 79 MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director Chesapeake Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6750 Old Bayside Road 20732 U.S.A. Funeral death , 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status r than "natural", or Item the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Aero-Space Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Rucker Addie Fox ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dora Rucker/Wife 6750 Old Bayside Road, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Department o Important: If any Injury or 04/12/2008 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequençe of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed >C 2001 use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 1 Ves 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes → No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowerthal, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 Registra Signature 31. Date filed (Month, Day, State 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2008 Kathy Lynn Rossick 8:30 P M 11, April 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Apr. 5, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F 185-46-7146 53 1955 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits

1 Yes 2 No

filed within 72 hours after death with the Maryland r 28a-f show notified at permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

\$ MD

Funeral

Director

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Division or Vital Records, P.O. Box 68760.

잃	MD	Frederic	etown						1 🛄	res Zi No			
ě	10e. Street and Nu	mber				10f. Zip Code					tizen of What Co	untry?	
a a	403 Glenb	rook Driv	<i>r</i> e			21769			1	USA			
ner	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.	S.	 Was Decedent of F If Yes, specify Cub 	lispanic Origi	in? (Specify	Yes or No-		14. Race - Ame		١,
2	1 Never Marr	ied 2X Married	1 ☐ Yes 21 N	10		1 ☐ Yes 2 X No		i dello i lici	an, 616.)		Black, White	e, etc.	
Completed by Funeral Directo	3 Widowed	4 Divorced	Year or Dates:				, ,				Specify: Whi	Lte	
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	Elementary/Seco	ondary (0-12)	College (1-4or 5 4	+)		stered Nur				Hea	1thcare		
d)	17. Father's Name	(First, Middle, Last))				Surname)						
ă O	Charles L	ezanic				Sophie Ernick							
	19a. Informant's Na	lailing Address (Street						(ip Code)					
	George Ro	ssick/hus	sband	Glenbrook Drive Middletown, MD 21									
	20a. Method of Disp		Damarral from Ctata	Disposition (Name of Date 20c. Location - crematory or other place)					ocation - City or	Town, State	9		
		5 ☐ Other (Specif	Removal from State y)	ake Cremat	ory 04	4/15/0	1 80	Be1	tsville	MD			
	21. Signature of Fu	ineral Service Licer	isee A			22. Name and Addre	ss of Facility	ation	Servi	ce	P.O. Bo	x 784	4
	12ev	ery FH	alillo	MO12	251	Beverly L.	Hecki	rotte.	P.A.	C1			
	23a. Part1. Enter t shock, or hea	he disease, or com art failure. List only	plications that caused one cause on each lir	the death	n. Do not	enter the mode of dyir	ng, such as c	ardiac or re	spiratory arre	est,		Approxi	mate Between
	Immediate Cause (disease or conditio	(Final				east Cance						5 mor	nd Death
	resulting in death)		Due to (or as										ICIIO
	Seguantially list on	nditions	b										
ner	Sequentially list co if any, leading to in cause. Enter once Cause (Disease or that initiated events	nmediate	Due to (or as	a consequ	uence of):								
аш	Cause (Disease or that initiated events resulting in death) I	injury	c										
Ĭ	resulting in death) i	Lasi	Due to (or as	a consequ	ence of):								
sician/Medical Examine			_d										
Me	IF FEMALE:		000 16	_6									
all	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death	3 Ectopic pregnanc	/			- 4	23d. Date of del Month	very Day	Year
SIC	1 ☐ Yes 2 ☐ 9 ☐ Unknown	XNo	4□Pregnant at 9□Unknown	time of de	eath	5 Other (specify)						,	
7	Part II. Other signi	ficant conditions of	contributing to death bu	ut not resu	ulting in th	ie underlying cause giv	en in Part I.		23e. Did tob	oacco	use contribute to	the cause	of death?
20									1 □ Y€	es 2	X No 3□Pr	obably 4	Unknown
upleted									24a. Was ar	n	24b, Were au	topsy findir	nos available
									autops perforn	y ned?	24b. Were au prior to death?	completion	of cause of
0	25. Was case refer	red to medical					26 Plans	of Dooth (C		2 💢 No	1 □Yes	2□ No	
2	examiner?		Hospital: 1 X Inpatie	nt 2 🗆	FB/Outpa	atient 3 DOA Oth	or.		heck only on		6 □Other (Spe	ni6.i	
-	27. Manner of Deat		28a. Date of Injur	ry	28b. Tim	ne of 28c. Injur			. Describe ho			энуу	
calloni	1 XNatural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day		k? Yes 2∐N	lo							
2	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju			, street, factory, office		28f.	Location (St	reet a	nd Number or Ru	ıral Route l	Vumber,
cer	- Landinicide				City or Town	ı, ətat	<i>b)</i>						
edical ce	29a. Certifier (Check only one)	leath occurred at the time, date and place, and due to the cau or investigation, in my opinion, death occurred at the time, dat				ause(s	s) and manner as d place, and due	stated. to the cau	se(s)				
×	29h Signature and title of certifier						29c. License number 29d. D				29d. Date signed (Month, Day, Year)		
· Goseph m Haggerty mb					D32407 April 13.				il 13, 2	2008			
	30. Name and add		completed cause of de										
			lenter Dr.	Rockv	ille.	MD 208	850						

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2008

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Sperte

32. Registrar's Signature

611 State

Registrar

PANKAT

31. Date filed (Month, Day, Year)

APR 1 6 2008

RIVER

NECK RD. # 109

BACK

201 32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For AMEND#8per FH4-15-567.256.06.000.0000.0000.0000.0000.0000.000	d / Department of H Certificate of L	lealth and Mental Hy	ygiene 0 0 8 3 9 7 2			
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ann		2. Date of D Month	Day Year 6.32 Mm			
	Examir Funeral Director		21 1-10 (31)	r) Burton	Location of Death S W	4c. County of Death May Day Omega iinth 917 9. Birthplace (State or Foreign Country)			
	faryland show	ō		, Town or Location Iver Spring		10d. Inside City Limits 1 ☐ Yes 2 [☑ No			
	with the M a or 28a-1 Les notifi	Funeral Director	10e. Street and Number 9809 Cherry Tree Lane	10f. Zip Code 20901		10g. Citizen of What Country?			
980	be filed within 72 hours after death with the Maryland ntal Hygiene. In the matural, or Items 23a or 28a-f show event, the Medical Evarrical must be notified at	þ	11. Marital Status 1 Naver Married 2 Married 3 Niwidowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:	lo- 14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036	d within 72 ho giene. or then "natur , the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired, Homemaker	during most of working	16b. Kind of Business/Industry OWN home			
/land	should be filed within and Mental Hygiene. I marked other then umatic event, its M	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Samuel Wertlieb	18. Mother's Name (First, Middle Bertha	e, <i>Maiden Sumame)</i> Yuter				
	od 2 ::		19a. Informant's Name/Relationship (Type, Print) Rochelle Claypoole , daughter		ber, City or Town, State, Zip Code) Spring, MD 20904				
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any Injury or other once.		20a. Method of Disposition 1\(\bigcap \) Burial 2 \(\bigcap \) Cremation 3 \(\bigcap \) Removal from State 3 \(\bigcap \) Ude 6 \(\bigcap \)	dens 4/15/2008	20c. Location - City or Town, State Olney, MD				
Balt	permit. Departimont Import any inj		21. Signature of Funeral Service License			ky Hebrew Funeral Home shington, DC 20012			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	0	g, such as cardiac or respiratory BRO VASCULAR	Interval Between			
68760,	death certificate be executed e attending physicien and ind for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of	ence of):					
P.O. Box 6	at the death certificat by the attending phy lached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (2 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of decent in the past 12 months are the past 12 months and 12 months are the past 1	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year			
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Division of	After Iune		27. Manner of Death V☐Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of linjury Work	at 28d. Describe	how injury occurred			
DIV		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, own, State)				
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	on and/or investigation, in my op	inion, death occurred at the time	, date and place, and due to the cause(s)			
,	with To Com		29b. Signatura and title of certifier Jallani		8595	29d. Date signed (Month, Day, Year)			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEDM LAICHAM, 2835 SMITH AVE, SUITE 213, BACK MI) 21269							
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 5 2008 32 Registrar's Signate	ITO Sparker					

08-03046	6
Sandra L	ee Reckley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	ealth and Menta	Hygiene

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		Registrar Certificate of Death Reg. No.											0 1001			
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day									Year		3, Time of Death			
Medical Exami	ner	Sandra 4a. Facility Name (if I					- 14	. City, Tow	1		/	April 19, 1	2008	County of		0936 hrs
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Funeral		5. Social Security Nu	mber	6. Sex	7. Age (In	yrs. last bir	thday)	If Under 1	Year Days	If Under Hours	24Hrs. 8	B. Date of Bi	irth(MM/DE	D/YYYY)	Foreign	place (State or
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any		Usual Residence of I	Decedent 0b. County		10c	. City, Town	or Location	n		_					· · · · · ·	10d. Inside City Limits
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daryland 28a-f show datones.	Director	10e. Street and Numl						10f. Zip Co	de				10g. Citize	n of Wha	at Count	гу?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		10901 Rum	Spring	s Road					217	73			Uni	lted	State	2S
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212 ould be Ment mark	To E	9a. Informant's Name/Relationship (Type, Print)										or Town	, State,	Zip Code)		
MD d 2 shc lth and n 27 is		Renee Levow / Daughter 10901 Run Springs Road, Myersv														
re, s 1 am of Hea of Hea If iten			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 24,									20c. Lo	cation -	City or T	own, State	
Page Page ment c		4 Donation 5	Other Sp	ecify:		Brook	Hill (Cemete	У		200		Yell	low S	pring	s, Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Fund	eral Service I	Licensee	140	4/22		me and Ad			Kee	ney & E Frederi	Basford	P.A	Fun	neral Home
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376 ificat ig phy s the	J/Me	IF FEMALE: 23b. Was decedent pi	regnant in the		outcome of		/ 2 Feta	al doath	3	Ectopic	nregnanc	v		Date of a	•	ay Year
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BO he dear the ar	hys	1 Yes 2 No		9Oliki								Look Pid		4.0		6.12.12
, P.O. Box 68 tres that the death certification is signed by the attending be detached for use as	by F	Part II. Other signific	cant conditi	ons contributing	to death but	t not resultir	ng in the ur	derlying ca	use giv	ven in Par	t I.			_		he cause of death? ably 4 Unknown
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Division pital or Attendii ours after death. teral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nul or Town, State)								d Numbe	r or Rur	al Route Number, City				
ospital hours ineral		4 Homicide Germined (Specify) Local Street 10500 Rum Springs Road									-					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only		nysician: To the be miner:On the basis and manner	of examina											
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		1 00	me 1	Une Wh	W).C.N	1.E.			April	20, 20	80	
		30. Name and address Margarita Ko		who completed cau Assistant Me				nn Stree	t, Ba	ltimore,	MD 21	201				
S! Regis	ate	31. Date filed (Month, Day, Year) \$2. Registrar's Signature														
Regis	util	APR 2 9 2008														

	18	1 - For State Registrar 1. Decedent's Name (First, Midd	dle, Last)		of Mary		epartmer Certificat			nd M	•	Reg. No		08	3. Tir	Q Q 7
Physici		Walter	Pre	ston	Rob	ertsor	sr.				April	Da 22	y 2	Year 2008	10):55A [™]
/Medi		4a. Facility Name (If not institution						Town, or I	Location of				. County			,,,,,,,
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uneral		5. Social Security Number	6. Sex			yrs. last birt	Months	r 1 Year	If Under 2 Hours		8. Date of Bir (Month, Da	av. Year))	9. Birthp	place (S	tate or Foreign
irector		212-32-0986	1,85	JW ZUF	7	74	Yrs.				Oct. 2	9, 1	1933	Mar	y la	nd
M 4		Usual Residence of Decedent 10a. State 10b. Count	ty		10	c. City, Town	or Location							1	0d. Insi	de City Limits
f sho	P	Maryland Ca	rrol	1				Varim	25						1 🗆	Yes 2 🛛 No
notii	Director	10e. Street and Number		•			10f. Zip	Keym Code	a i			10g. Cit	tizen of V	Vhat Cour	ntry?	
st be		1290 Bruc	evil	le Rd					21757					U.S.	Δ	
SE SE	Funeral	11. Marital Status		12. Was Dec	cedent Ever	r in U.S.	13. Was Dece	dent of His		in? (Spe	city Yes or No	0-		e - Americ	an India	an,
or ite		1 Never Married 2 Ma		1 ☐ Yes If Yes, G	2X No iive		1 ☐ Yes		Specify:	1 001101	mouri, oto.,		Specify		eto.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIFM/2/4a 25 per PHYS . 0878 4/29/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24 2008 4c. County of Death Clara Mae Riley /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Yea 12/6/1914 If Under 1 Social Security Number 7. Age (In yrs. last birthday Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 215-30-3041 Pennsylvania 93 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No Funeral Director Harford **Edgewood** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 214 Redbud Road 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Completed by 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert Troupe Reba Stanley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Liberatore (Granddaughter) 214 Redbud Rd. Edgewood, MD 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 3/27/08 Aberdeen, MD 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ormany Physician Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transi the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes ivision or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled n by the within 24 hours after dear To the Funeral Director completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 erson who completed cause of death (Item 23a) (Type, Print) 3 32 Registrar's Signa State Registrar

08-02966 Holly Melissa Schwa		nt in Black Indelib arvland / Departmer	le Ink. Ensure All Control Health and Ment	<mark>opies Are Legit</mark> al Hygiene	ole.						
•	- For State		te of Death	Reg.							
Physician/	1. Decedent's Name (First, Middle,Last) Holly Melissa	Schwall	Lenberg	2. Date of Death Month D April 16, 200	ay Year 0905 hrs						
	4a. Facility Name (if not institution, give street 2465 Lowery Road	and number)	4b. City, Town, or Location of Huntingtown		4c. County of Death Calvert						
Tullerai	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	day) If Under 1 Year If Under Months Days Hours	Min	MM/DD/YYYYY) 9. Birthplace (State or Foreign Country)Maryland						
Director	217-90-1055 1 M 2 Usual Residence of Decedent		Yrs.	08/18							
w any	10a. State 10b. County	10c. City, Town o			10d. Inside City Limits 1 Yes 2 No						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD Calvert 10e. Street and Number	Hunti	ngtown 10f. Zip Code	10g	. Citizen of What Country?						
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r death with the Maryland or items 23a or 28a-f sh imust he notified at once	11. Marital Status 12. V	rmed Forces?	 Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
er deat	3 Widowed 4 Divorced If Yes,	Yes 2 X No Give Year	1 Yes 2 X No specify:		specify: white						
ours aft	15. Decedent's Education (Specify only high	est grade completed) 16a. D	ecedent's Usual Occupation (Give uring most of working life, DO NOT	kind of work done 1 use retired)	6b. Kind of Business/Industry						
5-0036 ed within 72 hour of the wind that wattu other than "natu the Medical Exam Completed	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	Waitress		restaurant						
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215 be file arked a rent, th	Gene Phillip	Schwallenberg	g, Sr. Gaz . Mailing Address (Street and Nur	il Joyce	Walton er City or Town, State, Zip Code)						
D 21 should I and Mer natic ev	19a. Informant's Name/Relationship (Type, P Gail J. Schwallenber	<i>'</i>	2465 Lowery Road								
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 partment of Health and Mental Hygiene prortant: If litem 27 is marked other than jury or other traumatic event, the Medica	20a. Method of Disposition	20b. Place o	f Disposition (Name of cemetery, ory or other place)	Date	20c. Location - City or Town, State						
MOF Pages ent of I nt: If	1 Burial 2 X Cremation 3 Re		olitan Crematory	04-23-08	Alexandria, VA						
Saltin rmit. epartm nports	21. Signature of Funeral Service Licensee				eral Home, P.A. , Owings, MD 20736						
M B B B B B B B B B B B B B B B B B B B	23a. Part I. Enter the disease, or complication	ns that caused the death. Do no	t enter the mode of dying, such as	cardiac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and						
∦ /ledical	failure List only one cause on each line	2			D 0-						
A kaminer	or condition resulting in death) Due to	Due to (or as a consequence of):									
Jer Jer	,	o (or as a consequence of):									
ed nsit Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):									
executed an and al - transit	d. X UNPENDED 4M	Sa,27,28a-f, perMi	E 0879 5/8/08 TT								
760, cate be physici the buri	IF FEMALE: 23b. Was decedent pregnant in the	c. If yes, outcome of pregnancy	Ector	nic pregnancy	23d. Date of delivery Month Day Year						
the death certificate be exv to the attending physician ched for use as the burial-	past 12 months?	Pregnant at time of death	Other (Specify)								
the deat the deat ched for	Part II. Other significant conditions cont	Unknown ributing to death but not resultin	g in the underlying cause given in F	2011	bacco use contribute to the cause of death?						
P.O. es that the signed by be detac	l)			1Yes	2 No 3 Probably 4 Unknown						
Records, The law require. Figure has been signage 2 should be. Completed				24a. Was a autop							
Recc The lav cate ha				1 🗸 Yes							
ician: scertifi rector,	25. Was case referred to medical examiner?	tal: 1 Inpatient 2 ER/C	26.Place of Deat Outpatient 3 DOA Other	h (Check only one) Nursing Home 5	Residence 6 🗸 Other: Scene						
of Vigenthis there is a control of the control of t	1 Yes 2 No 27. Manner of Death	,	Time of Injury 28c. Injury at Wo	1	how injury occurred						
ion (tendin tendin tor: A tor: A the fur	1 Natural 5 Pending 2 Accident Investigation	Fnd 4/16/2008 Fn	d 8:46 am 1 Yes 2		Street and Number or Rural Route Number, City						
Division of Vital Records, spital or Attending Physician: The law require nears after death. Filled in by the funeral director, page 2 should be certification: To Be Completed	3 Suicide 6 X Could not be determined	28e. Place of Injury - At home, f (Specify) house	farm, street, factory, office building,	or Town S	wery Rd. HUrlington, MD						
bou hou hou hou hou hou hou hou hou hou h		To the heat of my knowledge de	eath occurred at the time, date and	place, and due to the caus	se(s) and manner as stated.						
To the Ho within 24 vithin 24 completed	one) 2 Medical Examiner:On and	the basis of examination and/or manner stated.	29c. License numb		and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
	29b. Signature and title of certifier		O.C.M.E. April 17, 2008								
	30. Name and address of person who com	pleted cause of death (Item 23a)	Penn Street, Baltimore, M	D 21201							
Stat	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Road &								
Registra	98 1213 22 1 / 11110										

08-02860 Beverly Thompson		Please Ty	oe or Protect of Monager	int in E laryland	Black II	ndelible artment o	Ink. Er	nsure h and	All Co Menta	pies al Hyg	Are Legit jiene	2.0	na 1397
Physician/	Re	distrar Decedent's Name (First, Midd Beverly Tho	le,Last)			inicate (Dean			2.	Reg. Date of Death Month Da April 12, 200	av Year	3. Time of Death 0914 hrs
Me Traillie		. Facility Name (if not institution	on, give stree				4b. City, T				, , , , , , , , , , , , , , , , , , ,	4c. County of Dea	ath
	_	Calvert Memorial Hos	6. Sex	7	Age (In vrs	last birthday)		Freder	If Under	24Hrs.	8. Date of Birth(Calvert MM/DD/YYYY) 9. E	Birthplace (State or
Funeral Director	5.	Secial Security Number 469-12-8924	1 M		87		Month:		Hours	Min.	01/14/1		eign Country) MN
any	-	sual Residence of Decedent Da. State 10b. County			10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
and Show	Ŀ		vert			Owings					140=	Citizen of What C	1 Yes 2 No
vith the Maryland s.23a or 28a-f show s e.notified at once.	10	De. Street and Number	: T				10f. Zip		00				Sunay.
with the s 23a c e notif		2070 Clear	12.	Was Deced	ent Ever in	U.S. 13. V	Vas Decede	2073 int of Hisp	anic Origii	n? (Spec	cify Yes or No-	U.S.A. 14. Race - Am White, etc	erican Indian, Black,
r death with or items 23 must be no	1	Never Married 2 X	1	Armed Forc Yes	es? 2 X No		Yes, specif			Puerto R	ican, etc.)	SpecifWhi	
rs after ural", uniner	<u> </u>	Widowed 4 Di 15. Decedent's Education (Sp	vorced If Yes or Da	ites:	completed)	16a. Deced	Yes 2 lent's Usual	Occupation	n (Give ki	ind of wo	rk done 1	6b. Kind of Busines	
72 hour al Exar	}	Elementary/Secondary (0-12		College (1-4		during	most of wo	rking life. I	DO NOT u	se retire	d)		
5-0036 lied within 72 hour. Hygiene. other than "natu. the Medical Exan.			- 1+>	2			Ho	memal	Ker 8 Mother's	Name (First, Middle, Ma	Own Hor	ne
	اد	7. Father's Name (First, Middle Frederick H.		on					Viv	rian	M. John	son	
2121 ould be fill d Mental b is marked tic event,	- 1	9a. Informant's Name/Relation	ship (Type, I	Print)		T.			and Numb	per or Ru	ral Route Numbe	er, City or Town, St	
Baltimore, MD remit Pages and 2 sho Department of Health and Important: If item 27 is injury or other traumati	2	Donald W. Sa: Oa. Method of Disposition	wyer/H	lusban	d 20t	2070 D. Place of Disp					Owings.	MD 20736 20c. Location - City	or Town, State
Ore, ges!atofHe	1	X Burial 2 Crematic		emoval fron	a l	crematory or edar Hi	other place)	1	04/1	6/2008	Suitland	d, MD
altim nit. Pa artmen oortand rry or o	-	Donation 5 Other 1. Signature of Funeral Service		1		22	2. Name and	Address	of Facility	Lee	Funeral	Home Ca.	lvert, P.A.
Dep Dep in ju		3a. Part I. Enter the disease,	M			8	3125 S	outhe	ern M	id Bl	vd. Ow	ings. MD	20736 Approximate Interval
Physician Vedical kaminer	1	failure. List only one cause mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	se on each lir se a. Athe	_{le.} erosclero		ovascular [1			Between Onset and Death
tecuted 1 and 1 transit	E Adillie	f any, leading to immediate ause. Enter Underlying Caus Disease or injury that initiated events resulting in death) Las	c		onsequence								
e executed cian and cirial - trans		UNPENDED	_ AN	ENDED				•					
tal Records, P.O. Box 68760, rian: The law requires that the death certificate be execrificate has been signed by the attending physician a ector, page 2 should be detached for use as the burial -	ly sicial mile		the 1 Jnknown g	Live bir Pregna Unknov	nt at time of vn	death 2 death 5	Fetal death Other (Sp	ecify) _		pregnar		23d. Date of del Month	Day Year
P.O. I ss that the gned by the detache	ੇ	Part II. Other significant con	ditions con	tributing to	death but no	ot resulting in t	he underlyir	g cause g	iven in Pa	ert I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death, and Director: After this certificate has been signed by the funeral director, page 2 should be detach that the control of the page 2 should be detach that the Deformal of	Completed										24a. Was a autops perform	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
cian: Certific	9 2 8 2	25. Was case referred to med examiner?	cal Hosp	ital;		✓ ER/Outpat	iont 3	26.Place	of Death Other			Residence 6	Other:
n of Viding Physical After this funeral direction.	٩,	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe		28a. Date of (Month,		28b. Time		28c. Inju	ry at Work	(?		ow injury occurred	
Division al or Atten s after death it Directors ed in by the	ပေျ	2 Accident In 3 Suicide 6 C	vestigation ould not be etermined	28e. Place (Specify)	of Injury - A	at home, farm,	street, facto	ry, office b	ouilding, e	tc.	28f. Location (S or Town, St		or Rural Route Number, City
bou hou y fill	<u>را ق</u>	4 Homicide 29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer:On	To the best	f examination	rledge, death on and/or inves	ccurred at t	ne time, da	ate and plant, death or	ace, and	due to the cause it the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To To with To to com	Med	29b. Signature and title of cer	and	manner st	ated			9c. Licens				29d. Date signed	(Month, Day, Year)
		and	2	_				O.C.	M.E.			April 13, 200	8
dew 3		30. Name and address of pers Ana Rubio MD. A	son who com				n Street,	Baltime	ore, MD	21201	1		
Star Registra	te ar	31. Date filed (Month Pay, Ye	^{2r)} 4 200	8 32. F	gistrar's Sig	nature	bork	,			OCME		

	_	1 - State Registrar Amend Item 3 per dr., g880,06/23/08dl	of Death	leritar r ry	Reg. N	2006	1397
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Larry Thomas Scruggs		April 9		2008 Year	3. Time of Death 0800 a M
Examine			Fown, or Location of Death Frederick			c. County of Death	1
Funeral Director		5. Social Security Number 234-56-5898 6. Sex 1 Months 7. Age (In yrs. last birthday) 4 Months 70 4 Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birt (Month, Da Oct 18	th y, Yea 193	9. Birth Coa West	nplace (State or Foreign intry) Virginia
Maryland -f show iled at	tor	Usual Residence of Decedent 10a. State	ick				10d. Inside City Limits 1 ☐ Yes 2 No
th with the 23a or 28a ist be noti	al Director	1995 Dares Beach road 10f 206	678		10g. C	itizen of What Cou ited Stat	untry? CES
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married If Yes, Special If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, Sive Year or Dates:	ent of Hispanic Origin? (Spe ify Cuban, Mexican, Puerto ?⊡ y No <i>Specify:</i>	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White Specify: Wh	, etc.
1215-0	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) grounds Kee	k done during most of worki e retired)	ing		Kind of Business/I	•
Maryland 21215-0036 Id 2 should be filed within 72 hours af lith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exemi	To Be Co	17. Father's Name (First, Middle, Last) George Oscar Scruggs	18. Mother's Name Anna Cat	(First, Middle, herine			Ellelic
Mary and 2 shoul alth and M 27 is mar er traumati	۲	19a. Informant's Name/Relationship (Type. Print) The Ima L. Scruggs- wife 1995 Dares	(Street and Number or Rura Beach Rd.Pri	nce Fre	er City eder	or Town, State, Z	.0678
Baltimore, permit. Pages 1 at Department of Hea Important: if item :		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Namcemetery, crematory or of Southern Memorials)			Dunk	Location - City or Kirk Mary	
Balt permit. Depart Import any inji			Address of Facility Rau				20676
\$76 ate be nysicia he bui	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		r respiratory ai	rrest,		Approximate Interval Between Onset and Death
BOX eath certing attending for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pre 5 □ Other (spe				23d. Date of deli Month	very Day Year
Kords, P.O. w requires that the deben signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did to		use contribute to	the cause of death? bbably 4 ☐ Unknown
- 0 -	Completed			24a. Was autop perfo 1∐ Yes		24b. Were au prior to c death?	topsy findings available ompletion of cause of 2 No
	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	26. Place of Death	(Check only o	ne)	6 □Other (Spec	
VISION OF Attending Phys r death. ector: After this by the funeral di	ation: To		4 🗆 Nursing Ho	28d. Describe I			ary)
DIVISION ai or Attending s after death. ai Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, building, etc. (Specify)	office	28f. Location (8 City or Tov	Street a vn, Sta	and Number or Ru ate)	ral Route Number,
	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, in my opinion, death occurr	and due to the red at the time,	cause date a	(s) and manner as and place, and due	stated. to the cause(s)
To t To t	Σ		License number D 40370			pate signed (Month	
RW 5+1	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Wisniewski, MD 110 Hospital Rd		Prince 1			
Stat Registra		31. Date filed (Month, Day, Year) APR 1 1 2008 APR 1 1 2008					

			State Registrar	State of Maryland / De	epartment of He Certificate of De	eath	Reg.	200	
ç	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last) S 4a. Facility Name (If not institution, give si Suburban Hospital	eymour STERN reet and number)	4b. City, Town, or Lo	ocation of Death		2008 Year 2008 4c. County of Dea Montgome	
Ц.	Funeral Director		5. Social Security Number 101-03-8923 Usual Residence of Decedent	M 2□F 7. Age (In yrs. last birthe	Months Days	Hours Min	8. Date of Birth (Month, Pay, Ye lug. 4, 1	9. Bir 914 Nev	thplace (State or Foreign ountry) V YORK
he Maryland	ns 23a or 28a-f show must be notified at	ector	10a. State 10b. County Florida Palm Bea	a Ch	Delray Bead	ch			10d. Inside City Limits 1 ☐ Yes 2 🐪 No
h with 1	st be n	al Dir	16760 Willow Creek	Drive	10f. Zip Code	33494		Citizen of What Co Jnited Si	-
5-0036 72 hours after death with the Maryland	iral", or items Examiner mu	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U.S. Atmed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II	13. Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 ☑ No	anic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: V	
_	3 00	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	Completed) (()	ecedent's Usual Occupatio Give kind of work done dur fe. DO NOT use retired) nufacturer	on ing most of working	g	Kind of Business	
Maryland 2	nt of Health and Mental Hygiene. If itom 27 is marked other than or other traumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Louis Stern				(First, Middle, Maid		741 61
Man nd 2 sho	alth and 27 is ma r trauma		19a. Informant's Name/Relationship (Type Martin L. Stern, Sc		lailing Address (Street and 9 Lamar Road	Number or Aural Bethes	Route Number, Cit	y or Town, State, 2 20816	Zip Code)
imore, Pages 1 a	Depcriment of Health a Important: If Item 27 Is any injury or other training.		20a. Method of Disposition 1	movar from State	isposition (Name of crematory or other place)	Da		Location - City or	
Baltin permit.	Deperti Importa any inj once.		21. Signature of Frine al Service Licensee		Torchinskys 254 Carroll	lebrew Fu	neral Hor	ne	20012
//	ysician Medical kaminer		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		enter the mode of dying, s			2011, 100	Approximate Interval Between Onset and Death
ox 68760, certificate be executed	hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, Leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Respiratory Fai Due to (or as a consequence of):	Same				
. BC	attending p for use as	Physician/Medic	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of del Month	ivery Day Year
	been signed by the should be detached	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in th	e underlying cause given i	in Part I.	23e. Did tobacc		o the cause of death?
al Recc	cate has be	Completed					24a. Was an autopsy performed? 1□ Yes 2☑1	prior to death?	utopsy findings available completion of cause of
Vita	s certifii director		25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	spital: 1 X Inpatient 2 ☐ ER/Outpa	Other	6. Place of Death ((Check only one) e 5 ☐ Residence	R Flother (Co-	-16.0
Division or Vital Records,	within 24 bours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Certification: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at Work? M 1 Yes	28 2 No	d. Describe how in	jury occurred	
Divi	within 24 hours effer death. To the Funeral Director: A completely filled in by the filled in the f	al Certifi	4 Homicide determined	28e. Place of injury - At home, farm, building, etc. (Specify) cian: To the best of my knowledge, d			If. Location (Street City or Town, Sti	ate)	
the Hos	the Fur	Medical	(Check only one) Medical Examine	er: On the basis of examination and/o and manner stated.	r investigation, in my opin	ion, death occurred	at the time, date a	and place, and due	to the cause(s)
(0.		20	29b. Signature and the of certifier			1302	(Date signed (Mont 1114/24	h, Day, Year)
		_	30. Name an address of person who com Atul Rohatgi, M.D.		enter Drive,	Rockvill	e, MD 20	0850	
44	Sta	te	31. Date filed (Month Day, Year)	32 Registrar's Signature	Accesses to				

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of rtificate of			ental H	ygien Reg. N	20	08	139	98
	Physici	an	Decedent's Name (First, Middle, Howard Rankin	•				2	. Date of D Month		ay	Year	3. Time of D	Death
	/Media	cal	4a. Facility Name (If not institution,		ahor)	4b. City, Town.	or Logotion o		April		2008 c. County o	f Dooth	11:00a	3 ^M
	Examir	ier	Hillhaven Nursi		ŕ	Ade 1		or Death					orge's	
	Funeral	7		S. Sex	7. Age (In yrs. last birthday	If Under 1 Year	If Under	24 Hrs. 8 Min.	Date of B	Birth			lace (State or	Foreign
	Director		225-36-8889	1 X M 2□F	86 Yrs.	Months Days	Hours	Se	pt.	9, 1	921		t Virg	
	and		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or L	ocation						10	0d. Inside City	/ Limits
	the Marylar 28a-f show	ţo	Maryland Dri	nce Georg	ge's Adel	nh i							1 □Yes 2	2 🔀 No
	or 28a	Director	Maryland Pri 10e. Street and Number	ince Georg	je s Adei	10f. Zip Code			-	10g. C	itizen of W	hat Coun	try?	
	23a c		2003 Evansdale	Drive		2078	33				USA			
	tems	Funeral	11. Marital Status	Armed For	dent Ever in U.S. 13. ces?	Was Decedent of If Yes, specify Cul	Hispanic Ori ban, Mexicar	igin? (Speci	fy Yes or N can, etc.)	No-	14. Race Black	- America , White, e		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	2 □ No e 1943-46	1 □Yes 2 No	Specify:				Specify:	Whi	te	
21215-0036	72 hours after death with the Maryland hatural", or Items 23a or 28a-f show deal Examiner must be notified at	ted	15. Decedent's	Education	16a. Dece	edent's Usual Occu				16b. I	Kind of Bus	iness/Ind	dustry	
215	within 7 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+) life.	kind of work done DO NOT use retire	ed) ed)	t of working						
121	filed within Hygiene. Ither than "				Brio	k Mason	T				struc			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f shoother traumatic event, Ita Modical Experiment must be notified at	To Be	17. Father's Name (First, Middle, La Isaac Clay Smit			R	losa F	er's Name (/ lorenc						
lary	2 shot and h		19a. Informant's Name/Relationshi	p (Type. Print)	19b. Mail	ng Address (Stree	et and Numbe	er or Rural I	Route Num	ber, City	or Town, S	State, Zip	Code)	
	1 and 2 Health em 27 I		Dolores Smith/W	ife		ansdale	Drive,							
Baltimore,	iges 1 ar nt of Hea : If Item 3		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disponentiate Highland	matory or other pla	nce) I	April		20c. I	_ocation - C	City or To	wn, State	
IFI	permit. Pages 1 Department of 8 Important: If Ite any injury or of		4 ☐ Donation 5 ☐ Other (Special Service Li		Highland Adventist				8008				Virgin	nia_
Ba	permi Depar Impor any ir	ŀ	Volcent /	1/1/		rancis d rancis d 00 Unive							MD 20	กดกา
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or c shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Cardi Due to (o	iac Arrhythmi or es a consequence of):	.a	ving, such as	cardiac or r	respiratory	arrest,			Approximate Interval Betwoonset and De Mins. O Yrs.	een eath
_	xecut and I-trans	Examiner	that initiated events resulting in death) Last		rtension or as a consequence of):							2.	5 Yrs.	
8760,	cate be executed physician and the burial-transit	dical E		d. Anemi								6	Mos.	
687	tificate ng phys as the	ledic		d. Throm:										
0	s that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	ant at time of death 5	☐ Ectopic pregnan☐ Other <i>(specify)</i>					23d. Date Mon		•	ear
ď.	s that gned t	by Pł	Part II. Other significant condition						23e. Did	l tobacco	use contrib	oute to th	e cause of de	ath?
ord	w requires to be a signal should be	ted	Gastrointestina	l Bleedir	ng, Alzheimer	's Disea	se		1 🗆	Yes 2	2 □ No 3	B□ Prob	ably 4 🖰 Ur	nknown
Reco	e la has	Completed			l l				24a. Wa auto per	s an opsy formed?	pr	ere autor ior to con eath?	psy findings ex npletion of cau	vailable use of
ta	Iclan: The certificate ector, pag		25. Was case referred to medical				26 Place	of Death (1 □Yes	2 ₹ N	0 1	□Yes	2 No	
Ξ	di is	To Be	examiner? 1 Yes 2 X No	Hospital:	patient 2 ☐ ER/Outpatie	nt 3 DOA Ot	her:	irsing Home			6 ☐ Other	(Specify	()	
o uo	Attending Pr r death. ector: After th by the funeral	tion: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		f Injury 28b. Time of Injury Injury	Wo		280			iry occurred			
.=	l or Attenc after death Director: J in by the I	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 28e. Place o	of Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		281	f. Location City or To	(Street a own, Stat	ind Number te)	r or Rurai	l Route Numb	er,
	To the Hospital or Attending Pr within Z4 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Example 1	Physician: To the la caminer: On the ba and mann	best of my knowledge, dea sis of examination and/or in er stated.	th occurred at the avestigation, in my	time, date an opinion, dea	nd place, an oth occurred	d due to th	ne cause(e, date ar	s) and mar nd place, ar	ner as st nd due to	tated. the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier)			se number				ate signed			
	(a) 1		> and and	M		D178	343			Apr	il 14	, 20	08	
	utl		30. Name and address of person will Vivek C. Vaid, M		of death (Item 23a) (Type, Toledo Terra)2, Hya	attsvi	ille,	MD :	20782			
	Sta	te	31. Date filed (Month, Day, Year) APR 15	32. Re	gistrar's Signature									
	Registr	ar	WIN TO	.000	we is po	will								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ... Year **Physician** Lemina Delzorene Saunders 10 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Yrs. 61 Director 166-44-7286 September 19,1946 Jamaica, W.I. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Lanham Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 U.S.A. 6800 Nashville Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2**X** No
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geico Insurance Computer Specialist permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel B. Salmon Nathaniel D. Weathers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6800 Nashville Road, Lanham, Maryland 20706 George D. Saunders - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment 04/16/2008 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Linnse 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SIP cardo pulmonary arrest **Physician** Anoxic encephalopathy /Medical Due to (or as a consequence of) Examiner Respirator Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Thpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ours after death.

21215-0036

Maryland

Baltimore,

ers,

aund

Certification: To Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Kenns

065909

4/11/08

30. Name address of person who completed cause of death (Item 23a) (Type, Print) 9118 Good Luck Rd., Lanham, MD.

Fasil 31. Date filed (Month, Day, Year)

15 2008



State

Registrar

			1 = For State Registrar	State of Maryla		rtificate of L		R	teg. No.	08	13984											
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Merlin S	mith Sr.				2. Date of Dea Month April	th Day 15, 200	Year 8	3. Time of Death 8:44 P. M											
	Examin		4a. Facility Name (If not institution, give sa	reet and number)		4b. City, Town, or	Location of Death		4c. County													
100			Washington County			Hagers			Washi													
i.	Funeral Director		215-20-7/33	7. Age (In yn 80	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day March 4	,1928	9. Birthpl Count Mary I	lace (State or Foreign try) and											
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c (ity, Town or Lo	cation				10	Od. Inside City Limits											
	laryla sho	'n	Md. Washingto		Smith s bu					"	y Yes 2 No											
	the N 28a-1 notifi	ect	10e. Street and Number			10f. Zip Code		1	I0g. Citizen of W	/hat Count												
	with ga or		59 W. Water St. P.	O. Box 25		21783			U . S													
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	i by Funeral Director		2. Was Decedent Ever in Armed Forces? XXYes 2□No If Yes, Give Year or Dates: 41-4		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No		pecify Yes or No- o Rican, etc.)	14. Race Black	- America K, White, G	etc.											
2-0	72 hc 'natu dical	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation Juring most of wor	king	16b. Kind of Bu	siness/Ind	ustry											
21215-0036	d within giene. er than " , the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		sembly L	ine		Truck Mfg.													
p	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	~				ne (First, Middle,		e)												
yla	ould I Men arke	မ	John R. Smith					. Fishacl														
Maryland	12sh hand 7ism maum		19a, Informant's Name/Relationship (<i>Typ</i> Jerry L. Smith (Son	,		ng Address <i>(Street a</i> Crystal 1				, ,	,											
e,	1 and Health em 27		20a. Method of Disposition			sition (Name of	alls DI	Date	20c. Location -													
Baltimore,	ages nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Re	manual fram Ctata	cemetery, crer	matory or other place irg Cemete		1 19.,	Smithsbu	-												
亞	nit. Partme		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	2. Name and Addres	ss of Facility	, i		•	-											
 Ba	Department of the service of the ser		Jele la	DWIS MO14	14 J.	L. Davis	Funeral	Sm	525 Brac ithsburg	lbury ,Mđ.	21783											
	Physician		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the de cause on each line.	Do not ent		g, such as cardia	c or respiratory are	rest,		Approximate Interval Between Onset and Death											
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):																	
	No of	ner	Sequentially list conditions, leaves. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a conse	uence of:																	
–	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):																			
68760,	cate be ohysicia the bur	d																				
P.O. Box 6	The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as		Physician/Me											IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	⊒Ectopic pregnancy]Other <i>(specify)</i>			23d. Dat	e of delive	ery Day Year
	that ted by		Part II. Other significant conditions con	ributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ibute to th	ne cause of death?											
rds	quires n sigr ald be	d by	DIAB	ctes me	llitu	2		1 🖼	es 2□ No	2 No 3 Probably 4 Unknown												
00	w rec	Completed	ituries	ensin				24a. Was a	an 24b. \	Vere autor	psy findings available											
Be	The la e has	шc	() //	, ,					med?	rior to cor leath?	npletion of cause of											
tal			25. Was case referred medical				26. Place of Dea	1□ Yes ath (Check only or		□Yes	2 No											
<u> </u>	ysicla is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er.	fome 5 ☐ Resid		er (Specify	<i>(</i>)											
ou o	Attending Physiclan: r death. ector. After this certification of the funeral director.	On Date of Injury On Time of One Injury On Time of								. ,												
Division or Vital Records,	E Gift	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spe	ce of injury - At home, farm, street, factory, office ding, etc. (Specify)			28f. Location (Street and Number or Rural Route Nul City or Town, State)														
	Hospital 24 hours Funeral etely filled	Medical C		cian: To the best of my k er: On the basis of exami and manner stated.																		
	To the l within 2. To the l complet	Me	29b. Signature and title of certifier			29c. Licens	e number	50	29d. Date signed	Month,	Day, Year)											
7			30 Name and address of person who co	noleted cause of death (It	em 23a) (Tvne	Print).			4/18	108												
Ċ	H 5+1	1		2en 12	911	e ffersi	n Al	UD.	smight.	Jeur	MOZITY											
	CA	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature					0												

Registrar DHMH 17 Rev 1/2001

State

APR 1 8 2008

08-02964	
Mahel J. Smith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

label J. Smith		For State	Maryland / Depaπ Certific	ent of Health ate of Death		ar riygierie Reg.	No. 20	08 1398
Physician/		Decedent's Name (First, Middle,Last)				2. Date of Death	Day Year	3. Time of Death 0339 hrs
≬િ `ેવl Examine ∤		a. Facility Name (If not institution, give str	eet and number)	4b. City, To	wn, or Location of	April 16, 200 Death	08 4c. County of Deat	L
		Easton Memorial Hospital		Eastor	1		Talbot	
Funeral	5	Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday) If Under Months		Min.	Co	rthplace (State or Foreign buntry)
Director	ó	112 - 62 - 0354 1	2 YF 54	Yrs.		July 2	5, 1953 N	naryland
any	_	0a. State 10b. County	10c. City, Town	n or Location	-			10d. Inside City Limits
<u>*</u> .	<u>.</u>	MD talbot	Ea	Ston		140-	. Citizen of What Cou	1 Yes 2 No
the Maryland a or 28a-f sh iffied at one	1	0e. Street and Number	1 1	10f. Zip (21601	109	u S A	nioy?
		1/3 - S. Locu 1. Marital Status 12	2. Was Decedent Ever in U.S.	13. Was Deceder	t of Hispanic Origin	n? (Specify Yes or No-		erican Indian, Black,
r death with		1 Never Married 2 Married 1	Armed Forces? Yes 2 No			Puerto Rican, etc.)	_	10.04
ural",	⋧┞	Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:	1 Yes 2		nd of work done	Specify: S 16b. Kind of Business	
2 3 3	naiduion 1	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of work	king life. DO NOT u	se retired)	<i>G</i> iv.	
5-0036 lied within 72 Hygiene. I other than " the Medical of		12		Deli- u	Jorker 18 Mother's	Name (First, Middle, M	SuperM	arket
	3 1 a 1	7. Father's Name (First, Middle, Last)	Smith		Do	rothu S	Wan	
212 nould b is mari	<u> </u>	9a. Informant's Name/Relationship (Type	, Print)		(Street and Numl	per or Rural Route Numb	per, City or Town, Sta	
ore, MD 2 ss 1 and 2 shou of Health and 1 If item 27 is 1		John Fos	ter 20b. Place	e of Disposition (Nam	e of cemetery,	Lane Ea.	20c. Location - City of	or Town, State
ages 1 ant of He		1 V Burial 2 Cremation 3	Removal Irom State	atory or other place)	toru	4/23/08	Lothian	Maryland
Baltimore, MD 2121 permit. Pages 1 and 2 should be f Department of Health and Mental Important. If item 27 is market injury or other traumatic event.		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. Name and	Address of Facility	and Home,	P. A.	MD, 21613
		Tanelle C. 1 23a. Part I. Enter the disease, or complica	Henry	Hen No	105h ing	thu St. Car	Mbridge	MD, 21613 Approximate Interval
Physician Medical		failure. List only one cause on each	line.			indiac or respiratory arro		Between Onset and Death
xaminer			Atherosclerolic calle to (or as a consequence of):	rd16Vascular	CIS AS			
		Sequentially list conditions, b	e to (or as a consequence of):					
		cause. Enter Underlying Cause						-
d ansit	X	events resulting in death) Last Du	e to (or as a consequence of):					
e exection and initial - tr	eg	X UNPENDED	MENDED7, permE, g879	5/7/08 TT				
760, ficate be g physic sthe bur	Z Me	IF FEMALE: 3b, Was decedent pregnant in the	23c. If yes, outcome of pregnand		3 Ectopic	pregnancy	23d. Date of deliv Month	ery Day Year
Box 687/ e death certifice the attending p led for use as th	icial	past 12 months? 1 Yes 2 ✓ No 9 Unknown	4 Pregnant at time of death		cify)			
the dea	≥ા	Part II. Other significant conditions	9 Unknown ontributing to death but not resul	ting in the underlying	cause given in Pa	rt I. 23e. Did to	bacco use contribute	to the cause of death?
P.C es that signed to be deta	2							robably 4 Unknown
v requires been should	ete					24a. Was a autop perfor	sy prior t	autopsy findings available to completion of cause of
Recc The lav cate ha	Completed					1 Yes		
tal ician: certi	8		spital: 1 Inpatient 2 🗸 ER		26.Place of Death		Residence 6 Ot	her:
of V g Phys fer this	<u>۽</u>	1 ✓ Yes 2 No 27. Manner of Death			28c. Injury at Work		now injury occurred	
icendin leath. tor: A	譩	1 X Natural 5 Pending 2 Accident Investigation			1 Yes 2			D. I. D. I. M. I. C.
Nivisior I or Attend after death Director: cd in by the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home (Specify)	e, farm, street, factory	, office building, et	c. 28f. Location (S or Town, S		Rural Route Number, City
Hospital 24 hours Funeral etely filled		29a. Certifier 1 Certifying Physician	: To the best of my knowledge.	death occurred at the	e time, date and pla	ace, and due to the caus	e(s) and manner as s	stated.
To the I within 2, To the F complete	Medical	one) Medical Examiner: C	on the basis of examination and/ and manner stated.	or investigation, in m	y opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
H × F ö	ž	29b. Signature and title of pertifier	. 0	29	c. License numberO.C.M.E.		29d. Date signed (April 16, 2008	
		30. Name and address of person who co	mpleted cause of death (Item 23	(a)			1.,, 15, 2550	
			nt Medical Examiner	111 Penn Street	t, Baltimore, M	D 21201		
Sta		31. Date filed (Month, Day, Year) APR 2:3 200	32. Jegistrar's Signature	hand				
Registr			The state of the	ORIGINAL				
DHMH 17 Rev 1/20	VI	OCME	,					

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

micece Na

CHIH 223 1 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

mei st,

29d. Date signed (Month, Day, Year)

Alchor

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

Day

21,

2008

NC

Black

Day

24a. Was an 1[XYes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 □ No

Year

4c. County of Death

3. Time of Death

6:45A

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐Yes 2 ☐ No

2. Date of Death

April

1. Decedent's Name (First, Middle, Last)

Μ.

4a. Facility Name (If not institution, give street and number)

Sanders

Willie

Physician

/Medical

Examiner

Directo

Be

2

Examiner

Physician/Medical

Completed

Be

Certification:

Medical

State Registrar

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

Funeral

Director

Holy Cross Hospital Montgomery Spring Silver 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Hours 1 **3** M 2 ☐ F 246-50-7203 Dec.28,1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. PG Suitland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20746 2813 Sunset Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber 11 DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Sunset Lane
Suitland, Md. 20746

20b. Place of Disposition (Name of Date <u>Wilhelmina Sanders/wife</u> 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cem. 4/26/08 | Clinton, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part V Enter the disease, or complications that call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be cause on such line. Immediate Cause (Final disease or condition resulting in death) Hypotension Due to (or as a consequence of) Hypoglycemia
Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Lines the distribution of the cause (Disease or injury that initiated events resulting in death) Last Severe Cardiomyopathy Due to (or as a consequence of Chronic Renal Failure 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No factory, office	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowledge, death oner: On the basis of examination and/or inversand manner stated.	ocurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)			
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)			
1 / Chang	no no	20056063	3 4/2/08			

2 ER/Outpatient 3 DOA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 XInpatient

Kanwaljit Nagi, $M_{\bullet}D_{\bullet}$ 1500 Forest Glen Rd., Silver Spring, Md.20910

Year.

32. Registrar's Signature

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- For	partment of Health and Nertificate of Death		ne . _{No.} 2008	-21148 13486				
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death					
	Physici		Brianne Dalynn Smith		APRIL 16 2008						
4	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	-				
q	Examir	er	The Johns Hopkins Hospital	Baltimore City		L o Biri					
	Funeral		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthda 7. Age (// If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 2	8. Date of Birth (Month, Day, Ye Apr. 14.	ar) Count	lace (State or Foreign ry) y l and				
	Director		Usual Residence of Decedent		INDIA 17,	20001 1141	y runu				
	show d at		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits				
	Man a-f st fied a	io	Maryland Carroll	Westminster			1 ☐ Yes 2 🔀 No				
	or 28	Director	10e. Street and Number	10f. Zip-Code	10g.	. Citizen of What Coun	try?				
	h wit	a l	942 Muller Rd.	21157		U.S.	Α.				
	deal ems	Funeral		 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,					
98	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show the, the Medical Exeminer must be notified at	ΥĒ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 🔀 No Specify:		Specify:					
Ö	ura",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	16	Wf b. Kind of Business/In	nite				
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryls of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Ru	ıral Route Number, C	City or Town, State, Zip	Code)				
	1 and 2 Health a tem 27 is		Shawn Smith/ father 960	9 Liberty Rd. Fro	ederick, N						
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State 20b. Place of Discemetery, of	sposition (Name of rematory or other place)	Date 20	c. Location - City or To	wn, State				
<u><u>Ĕ</u></u>	Pag ment ant: i		4 Donation 5 Other (Specify)	eek Cemetery 4/21	/2008 ni	r. Linwood	, MD				
<u>a</u>	permit. Pages 1 Department of F Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ha							
	₹0 <u>= </u>		23a. Part 1. Enter the disease, or complications that caused the death. Do not			r, MD 21770	Approximate				
			shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	ι,	Interval Between Onset and Death				
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	/Medical Examiner		Due to (or as a consequence of).	EMORRHAGE							
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Box 68	nding use	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive	,				
	that the death certific ed by the attending p detached for use as	Physician/M	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year				
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	To the H within 24 To the F complet	Medical	one) and manner stated. 29b. Signature and title 3 certifier	29c. License number	29d	I. Date signed (Month,	Day, Year)				
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€			30. Name/and address of person who completed cause of death (Item 23a) (Tyr			1 1					
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		ate	31. Date filed (Month, Day, Year)								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day 2008 Lue Ennice Sewell 19, 12:08AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Gilchrist Center for Baltimore Hospice Care Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 7. Age (In vrs. last birthday) 1□ M 2 F .86-09-0252 1919 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No White Hall Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21161 20104 Kirkwood Shop Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing General Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertie J. Blevins Thurman C. Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Jean Daily/Daughter 2001 Reuter Rd., Timonium, MD 21093 20b. Place of Disposition (Name of Bel Alr Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date April 23, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Bel Air, 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc. Milal & Menna 19 S. Main St., Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final 12Men year disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🕍 Unknown 24a. Was an autopsy performe 1 □Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760 F 80 LE

Hospital or Attending Physician: The law requires that the death certificate be executed Ash brus after death.

Funeral Director: After this certificate has been signed by the attending physician and etel plicector. In the property plage 2 should be detached for use as the burial-transit energy filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Physician

/Medical

Examiner

Funeral

Director

28a-f show

event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Marical Examinational Examinational Examinations 2006.

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

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Certification: To

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1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29c. License number

D 25643

29d. Date signed (Month, Day, Year)

Baltrune ND

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

APR 29



Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13^{Day} 2008 Apr. 2:30P M Anna M. Simonick /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 26209 Johnson Dr. Damascus Montgomery 8. Date of Birth Month, Day 1 997 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 ☐ M 2 🗙 F 100 189-30-6734 Director Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MD Montgomery Damascus 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24444 Cutsail Dr. 20872 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🕱 No 2 Specify. Specify: White 3 Widowed 4 □ Divorced Year or Dates: 'natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) f Health and Mental Hygiene. College (1-4or 5+) machine co. stenographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvester Kuna Mary Vodzeak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrea Finucane (Daughter) 24444 Cutsail Dr., Damascus, MD 20872 20a. Method of Disposition 20b Place of Disposition (Name of United Morthampe r other flace) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once, PA 1 🔲 Burial □ Cremation 3 ☑ Removal from State 5 Other (Specify) Sorrow Cemetery 4/16/08 Greenfield Twnshp. 4 ☐ Donation 21. Cignariy Funeral S Donald B. Thompson Funeral Home P O Box 18, Middletown, MD 21769 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 4 norixin 2 montas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Waturat Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not he 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar

29b. Signature and title of certifier

David

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registra Signature

Hard

29c. License number

29d. Date signed (Month, Day, Year)

Phillip Pr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🦪 300 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) △Month 8, 2008 **Physician** Sallot James 2230 toril /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Rehab a Nursing (Salisbury Wicomico If Under 1 Year | If Under 24 Hr 8. Date of Birth (Month, Day, Yea 9/15/1936 9. Birthplace (State or Foreign Country) Indiana 5. Social Security Number 7. Age (In 🖛 last birthday) **Funeral** 1**X** M 2□ F Months Days Hours 305-36-7586 71 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ▼Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after begartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or Iter any Injury or other traumatic event the most in the most in the most intermediate. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: white þ Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) restaurant owner food service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Sallot Dora Dean Killian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7181 Quantico Rd., Hebron, MD 21830 Therese Devenyns/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 4/12/08 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Insee 22 Name and Address of Facility Home Professional Association Kell RAte 501 Snow Hill Rd., Salisbury, MD 21804 (ESP 23a. Part1. Enter the disease, or compretations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 /Medical Due to (or a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has autopsy performe 1 ☐ Yes 2□ No 2 4No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10th

State Registrar William H. Robins, M.D., 200
31. Date filed (Month, Day, Year)
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2008

Registrar's Signature

คายสระชาชุดอย่างการทำใหญ่ เป็นสามารถ Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Eupha Pauline Struthers 08 /Medical Strothers 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsum Reg 344/36414 HICOMIC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Days 1 □ M 2 🖺 F Director 236-20-6905 84 25, 1923 West Virginia Usual Residence of Decedent r 28a-f show notified at 10c, City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director DE Sussex Seaford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7878 Nanticove Drive 19973 U.S.A. must Funeral 7 Is marked other than "natural", or items traumatic event, the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 23 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) filed withir Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress 12 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Melvina Duffield Joseph Siers ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Robert L. Michael (Husband) 7878 Nanticove Drive Seaford, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 4-14-08 Delmar, Delaware 22. Name and Address of Facility
Watson-Yates Funeral Home
Front & King Street Seaford, DE 21. Sign sture of Funeral Service 19973 dons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part1. Ever the dishock or heart fa Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed that initiated events and burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the ding use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Party 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1□ Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 3 DOA 2 1 Impatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? f Death 28d. Describe how injury occurred After Certification: or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Fo the Funeral 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b, Signature and t 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY Md KERRIGAN MD 1 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ∧ Month **Physician** Margaret Ann Taber OVI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₽F 10/09/1941 66 169-32-3947 Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Calvert Dunkirk 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? or a death with 11216 Lakeview Drive items 23a c 20754 U.S.A. Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married ŏ 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced "natural", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Pages 1 and 2 should be filed withment of Health and Mental Hygien trant; If Item 27 Is marked other thiury or other traumatic event, the Legal Secretary 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Dunmire ဂ္ Jean D. Barrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Milton Taber/Husband 11216 Lakeview Drive, Dunkirk, MD 20754 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) MD Veterans Cemetery | 04/16/2008 | Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral HOme Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tag resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any the limit distributed ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ å 2 No 3 Probably 1 ☐ Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a, Was an autopsy performed? Yes 2 No Yes or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2∐No 1 ☐ Yes 1 Minpatient 3□ DOA Certification: To 2 ER/Outpatient this 27. May er of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Gen Burnie, 10. 2061

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

279

32. Registra Signature

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2008

State

Registrar

31. Date filed (Month, Day, Year)

APR

32. Registrass Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State

Physici /Medic Examin

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

I = Registrar Certificate of Death Reg. No.											1344	1				
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	23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Dist only one cause on each line. Approximate Interval Between Onset and Death															
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State

Registrar

31. Date filed (Month, Day, Year)

APR 15 2008

2. Registrar's Signature

State Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2008

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Month Linda Lee Woods 2008 9 /Medical Apri1 11:28 a 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2605 Apple Way Dunkirk Calvert If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 213-46-9365 61 9/15/1946 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 No Director MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2605 Apple Way 20754 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Paul Morton Marion Juul 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Gill/Daughter 1530 Live Oak Dr., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crem. 4/11/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Raymond-Wood F.H., PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cancel MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death P.O. 5 Other (specify) the 9□Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / filled in by the fi 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

LRW State

31. Date filed (Month, Day,

29b. Signature and title of certifie

32. Registras Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day : 05PM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Norcester SING Date of Birth (Month, Day, Age (In yrs. st birthday 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 M F Hours Min. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumants. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ennic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it ton ater trec. NOW 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5 ☐ Other (Specify) 21. Sanature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CERCARO VASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2-XNo Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an was autopsy performed? page 2 certificate 2 No Division or Vital Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 22010 2 ER/Outpatient 3□ DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifien D0062172 MD

DHMH 17 Rev 1/2001

State

Registrar

Sharad

31. Date filed (Month, Day, Year) APR 1 6 1604 MARKET ST

32. Regisfrar's Signature

CITY

MD

Polomoke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SAMAL, MD

Registrar DHMH 17 Rev 1/2001

State

Pratima Pathak, M.D.,

15

2008

31. Date filed (Month, Day, Year)

APR

32 egistrar's Signature

1500 Forest Glen Rd., Silver Spring, MD. 20910

Division or Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

31. Date filed (Month, Day, Year) State APR Registrar

29b. Signature and title of certifier

15 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Theodore Li, M.D. 3301 New Mexico Ave, N.W. Washington DC

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DC 14603

29d. Date signed (Month, Day, Year)

April 14,2008